



## **REFERRAL FORM**

Referral Date: \_\_\_\_\_

Baby's Name: \_\_\_\_\_

DOB: \_\_\_\_\_  Male  Female

Health Card #: \_\_\_\_\_ VC: \_\_\_\_\_

Address: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Phone #: \_\_\_\_\_

Reason for Referral:

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Referring Practitioner(Printed name): \_\_\_\_\_ Billing #: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

### NOTE:

- \*Referrals can only be made by Medical Doctors, Midwives or Nurse Practitioners
- \*Incomplete referrals will be returned to your office
- \* Appointment request must be submitted by patients at [www.ibconline.ca](http://www.ibconline.ca)

Please fax completed form to the number below.

1255 Sheppard Avenue East • Toronto, ON Canada • M2K 1E2

[www.ibconline.ca](http://www.ibconline.ca) • [clinic@ibconline.ca](mailto:clinic@ibconline.ca)

Phone: 416-498-0002 fax : 416-498-0012