REFERRAL FORM

Referral Date:_____

Baby's Name:_____
DOB: _____ ☐ Male ☐ Female
Health Card #:_____VC:_____
Address:_____
Parent/Guardian:_____Phone #: _____

Reason for Referral:
_____
_____
_____
_____
_____
_____

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

Please fax completed form to the number below.

58A-2700 Dufferin St. Toronto ON, M6B4J3
www.ibconline.ca • clinic@ibconline.ca
Phone: 416-498-0002
fax: 416-498-0012 or 416-352-1224