Bridgepoint Hospital
14 St. Matthews Rd.
Toronto, ON M4M 2B5
416-461-8252 x2371
bridgepointhealth.ca

BRIDGEPOINT
active healthcare

Outpatient Clinic Referral Form

FAX: 416-461-2089

Patient Information:

Name: _____ Address: _____

Date of birth (dd/mm/yy): _____ Health card: _____

Daytime contact number: _____ Family doctor: _____

Contact person (if not patient) and Phone # _____

Service referred for:

Geriatric Psychiatry – Dr. Lachmann

Reason for referral or question:

Referring physician information:

Name: _____ Physician billing #: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

Signature: _____ Date: _____

Attach: Recent lab data, relevant specialist referrals, recent neurological imaging, current medication list and allergies.

Please fax referral form to 416-461-2089. We will contact the patient directly for a referral.