NORTH TORONTO SURGICAL

PATIENT REFERRAL FORM

1275 Finch Avenue West, Unit 605
Toronto, Ontario M3J 0L5
Tel: (416) 742-2961 Fax: (416) 742-0076
info@northtorontosurgical.com

☐ URGENT (1-3 DAYS)

PERSONAL INFORMATION

Surname, First Name _____

Health Card Number _____ **Date of Birth** _____ (dd/mm/yyyy)

Address _____
(number) (street name) (unit) (postal code) (city)

Phone Number _____ **E-Mail** _____

PLASTIC SURGERY

Dr. Haley Augustine

- ☐ Mole/cyst
- ☐ Skin cancer
- ☐ Trigger finger
- ☐ Carpal tunnel syndrome
- ☐ Cosmetic consult
- ☐ Medical Botox: Migraine/ TMJ/Hyperhydrosis

VASCULAR SURGERY

Dr. Aaron Beder, MD, FRCSC
Dr. Kerry Graybiel, MD, FRCSC
Dr. Luis Figueroa, MD, FRCSC
Dr. Asem Saleh, MD, FRCSC

OR
First available surgeon

- ☐ Varicose veins
- ☐ Edema
- ☐ Arterial disease
- ☐ Aneurysm
- ☐ Vascular Medicine
- ☐ Wounds

Medical History/Medication List: _____

_____

_____

Name of Referring MD/NP _____ **OHIP #** _____

Phone/Fax _____ **Date of Referral** _____ (dd/mm/yyyy)

Signature _____