GRAND GENESIS HEALTH
Richmond Hill Medical & Surgical Centre

Phone: (289) 597-7676
Fax: (289) 597-7675
www.grandgenesishealth.com
reception@grandgenesishealth.com

REFERRAL FORM

DATE OF REFERRAL:

_____

SPECIFIC SERVICE REQUIRED:

☐ Endoscopy & Colonoscopy	☐ Gastroenterology	☐ Allergy & Immunology
☐ General Surgery	☐ Orthopedic Surgery	☐ Plastic Surgery
☐ Rheumatology	☐ Anemia – Iron Infusion	☐ IBD

SPECIALTY CLINICS:

☐ Gastric Botox	☐ Gastric Sleeve	☐ Botox & Filler
☐ Mole Removal – Biopsy & Skin Lesions	☐ Lumps & Bumps, Skin Tags, Cysts	☐ Lipoma removal
☐ Surgical Tattoo Removal	☐ Rezum	☐ Circumcision

Reason for referral: _____

_____

Name of Requested Physician: _____

REFERRING DOCTOR INFORMATION:

Name: _____ Billing #: _____

Contact Number: _____ Address: _____

Fax Number: _____ Signature of Referring Physician: _____

Please fax all referral forms to (289)597-7675 OR (905)597-1657 & include relevant pathology reports, blood work, & diagnostic imaging