Dr. P. Lo Medicine Professional Corporation
Patrick Lo, MD, MDiv, FRCP(C)
502-245 Fairview Mall Drive, Toronto, ON M2J 4T1
Tel: (647) 350-7675 Ext. 1 • Fax: (905) 209-0800

PLEASE PRINT LEGIBLY

Date of Referral: ______________________________

Referring Physician Information:

Name: Dr. ______________________ **Billing Number:** ______________

Office Phone #: ______________________ **Office Fax #:** ______________________

Office Name and Address: ______________________________

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Specialty: ______________________________

Patient Information:

Last Name: ______________________ **First & Middle Name:** ______________________

Birthdate (DD/MM/YYYY): ______________ **Age:** ______ **Gender:** ____________

Health Card (OHIP) # (e.g. 1234 – 567 – 890 – XX): ______________________

Home #: ______________ **Work #:** ______________ **Cell #:** ______________

Address: ______________________________

City: ______________ **Province:** __________ **Postal Code:** __________

E-mail: ______________________________

Presenting Concern:

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Please Note: Dr. Lo can only provide a one-time consultation assessment. Faxing this form back to our clinic indicates that both referring physician and patient understand Dr. Lo only provides a one-time consultation and no follow-up is available. We will contact the patient directly once there is a time available for appointment.