# CHARING CROSS MEDICAL ™

## Joint Injections, Skin Health & Women's Health Clinics


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## REFERRAL FOR ASSESSMENT

**Patient ID (affix label):**
DOB:
ADDRESS, PHONE:
HEALTH CARD NUMBER:
PRIVATE INSURANCE: YES / NO

**REFERRING MD NAME (stamp/label):**
REFERRAL DATE: ____________________
ADDRESS, PHONE, FAX:
BILLING NUMBER: ____________________

SIGNATURE: ________________________

**REASON FOR REFERRAL:**

☐ Joint assessment and injection (provide details on the side)

☐ Injection of joint or bursa under u/s guidance

☐ Viscosupplementation injection for knee/hip arthritis

☐ Platelet rich plasma injection of tendon, ligament or joint

☐ Skin cancer, pre-cancerous or benign lesion biopsy/excision

☐ IUD insertion  PAP smear  Women's health (circle one)

DETAILS: ____________________________
______________________________________
______________________________________
______________________________________
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______________________________________

**IMPORTANT COMORBIDITY:** ________________________________________
________________________________________

**MEDICATIONS:** ________________________________________

**ALLERGIES:** ________________________________________

**IMAGING REPORTS (IF AVAILABLE):** ________________________________________

**PATIENT'S PHARMACY:** ________________________________________

***THANK YOU FOR YOUR REFERRAL!***

***ASSESSMENTS DO NOT AFFECT FHO OR GP BILLINGS***