

WRH BYNG CLINIC REFERRAL FORM

Address - 10-1275 Walker Road, Windsor, ON, N8Y 4X9 Hours - Mon - Thurs 9 am - 4:30 pm (closed 12-1 pm)

Patient Sticker

Patient Information			
Last Name:	First Name:		
Date of Birth (mm/dd/yyyy)://	HCN or IFH #:		Ver. Code:
Address:			
Street	City		Postal Code
Phone Number:			
Referring Physician Information			
Name:	Billing Number:		
Address: Street			
Street	City	Province	Postal Code
Phone Number:	Fax Number:		_
Family Doctor: ☐ Same as above ☐			
Attach the following to go with this Referral form			
 □ CD4 and HIV viral load test result(s) □ HIV Genotype □ Serology including Hepatitis A, Hepatitis B, Hepatitis C, CMV, and Toxoplasma IgG □ HCV genotype and HCV RNA □ Medication List □ Immunization History □ Consult Notes □ ART History □ Other relevant test results such as labs and diagnostics ⚠ If the patient is currently on HIV medication, provide at least 90 days of medication for the patient 			
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Fax completed form to the WRH Tecumseh Byng Clinic @ 519-254-3793 → Approximate Wait times: ○ New Diagnosis: 4 weeks ○ Treatment experienced HIV infection on ART: 3 months → For questions, contact Admin Assistant at 519-254-1661			
Referring Physician Signature Date of Referral (mm/dd/yyyy)			