Dr. Ahmed Ziada, MD, FRCPC

Internal Medicine/Endocrinology & Metabolism
Clinical Pharmacology & Toxicology

CONSULTATION REQUISITION

PATIENT INFORMATION

Name: ________________________________ Date of Birth: _________________________

Address: ____

Patient Telephone #

Home: ________________________________ Work: _______________________________

Cell: __________________________________

Health Card #: __________________________ Family Physician: ______________________

REFERRING PHYSICIAN: ____

Billing #: _______________________________

Reason for Referral:

Please provide investigations and/or patient profile that may assist the doctor pertaining to referral.
Have patient bring his/her current Health Card and Medication List.
Thank you.

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