

REFERRAL FORM

Urgent COVID-19 Care Clinic



London Health
Sciences Centre

Fax Number: (519) 663-3243

Patient information

Name _____

Phone number _____

Date of birth (dd/mm/yy) _____

Address _____

City _____ Postal Code _____

HCN (version code) _____

Physicians: Dr. Megan Devlin, Dr. Inderdeep Dhaliwal, Dr. Jaclyn Ernst, Dr. Marko Mrkobrada, Dr. Michael Nicholson, Dr. Erin Spicer

Referring Physician _____ Date of Referral (dd/mm/yy) _____

Signature _____ OHIP Number _____

Patient being referred from:

- Family Physician's Office
- Emergency Department at _____ Hospital
- Screening Centre
- Post-Discharge from Hospital

Date of onset of COVID-19 symptoms: _____

Date of positive COVID-19 test: _____

To facilitate triage, please provide the following mandatory information:

Age _____

Height _____

Weight _____

- History of heart disease (coronary artery disease, heart failure or arrhythmias)
- History of lung diseases (COPD, asthma, interstitial lung disease, bronchiectasis, pulmonary hypertension)

Patient aware of referral:

- Yes
- No

If patient is referred from an emergency department, please attach the following to this referral:

CBC, Lytes, Cr, ALT/ALP, CRP, Ferritin, LDH, CXR report and ECG

O₂ saturation on room air: _____ % Blood pressure: _____ / _____

Please note: We are not able to accommodate referrals from Long Term Care Facilities at this time. We are happy to discuss patient care with LTC physicians.