Eastern Health

Influenza Assessment Clinic Referral

Fax: 709-752-4732

AS6700 2139 04 2020

Name:

HCN:

Date of Birth:

Date: DD/MONTH/YYYY

Patient Information:

Telephone Numbers: (Home) _____ (Cell) _____(Work) _____

Street Address/Box Number: _____

City/Town: _____ Postal Code: _____

Referring Physician Information:

Address:_____

Telephone:_____ Fax:_____ Postal Code:_____

Physician's Name:_____ Physician's Signature:_____

Reason for Referral: (For appropriate triage and booking, include patient medications, relevant tests and history.)

Submit Form