



# REFERRAL RESPONSE FORM AND FAX TRANSMISSION SHEET

*Patients Declined*

## FAX TRANSMISSION

**Fax To:**

<input type="checkbox"/> University Health Network 416-603-5237	Attention: _____
<input type="checkbox"/> St. Michael's Hospital 416-864-6062	Attention: _____
<input type="checkbox"/> Mt. Sinai Hospital 416-586-8791	Attention: _____
<input type="checkbox"/> Other _____ (specify)	Attention: _____

**Fax From:** Name: \_\_\_\_\_ Phone/Pager:: \_\_\_\_\_  
 Organization: \_\_\_\_\_ Unit:: \_\_\_\_\_

## RESPONSE FORM FOR PATIENTS DECLINED

**Re Patient:** First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

**Declined because of (please check all that apply):**

- Cognitive issues (specify) \_\_\_\_\_
- Behavioural issues (specify) \_\_\_\_\_
- Special needs (specify): \_\_\_\_\_
- Medical complexity (specify): \_\_\_\_\_
- Other (specify) \_\_\_\_\_

**Comments:**

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