Soldiers' MEMORIAL HOSPITAL Orillia

Apply Patient Label Here with min. of Name, DOB, Health Card #

Anesthetic Consult Request Form

**Note: Incomplete or illegible forms will be sent back requesting amendment*

Referral Information:

Date Sent	
Referring Clinician	Physician Name (print): _____ Physician Signature: _____ Physician CPSO #: _____
Office Telephone #	
Office Fax #	

Patient Information:

Patient Name	
Patient DOB	
Primary Phone #	
Health Card # & Version Code	
OSMH MRN (if applicable)	
Reason for Request:	
Medications	
Diabetic	Yes ☐ or No ☐
Please enclose pertinent notes e.g. investigative testing, consult notes, etc.	