



**Specialist Referral Form**  
CONFIDENTIAL

**REFERRING PHYSICIAN INFORMATION**

Physician Name

CPSO Number

OHIP Billing Number

Clinic / Practice Name

Phone

Fax

Email

Clinic Address

**PATIENT INFORMATION**

Patient Full Name

Date of Birth (YYYY-MM-DD)

OHIP Number

Version Code

Phone

Email

Address

**REFERRAL DETAILS**

**Service Requested:**

- Diabetes Type 1 (OHIP)    Diabetes Type 2 (OHIP)  
 Respiriology (OHIP)    Other: \_\_\_\_\_

**Urgency:**

- Routine    Semi-Urgent (within 2 weeks)    Urgent (within 48 hours)

**Reason for Referral / Clinical Question:**

**Relevant Medical History:**

**Current Medications & Doses:**

**Recent Lab Results (A1C, eGFR, lipids, PFTs, etc.):**

**Additional Notes:**

**CONSENT & SIGNATURE**

I confirm that this referral is submitted by a licensed Ontario physician or nurse practitioner, that the patient has been informed of and consents to this referral, and that the information provided is accurate. I understand that Curantis Specialty Care may use anonymized clinical data for research and quality improvement purposes as outlined in their Privacy Policy (curantiscare.ca/privacy).

Physician Signature

Date (YYYY-MM-DD)