

KW Plastic & Reconstructive Surgery Associates

Dr. Jessica Shih MD FRCSC
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NEW REFERRAL FORM

Please fax form to (226) 686-1686

Date: _____

Patient Information:

Name: _____ DOB: / /
DD MM YY

Gender: Email: _____

PCP (if not referring physician): _____

HCN: _____ - _____

Phone #: _____ Alt #: _____

Address: _____

Referring Physician Information:

Name: Dr. _____

PCP/Specialty: _____

Billing #: _____

Phone #: _____

Fax #: _____

Address: _____

REFERRAL INFORMATION

Referral to: Dr. Jessica Shih, *Hand & Wrist Specialist, Plastic & Reconstructive Surgeon*
 Dr. Miliana Vojvodic, *Breast Specialist, Plastic & Reconstructive Surgeon*
 Either (Earliest available appointment)

Urgency: Urgent (within 1-2 weeks) Elective

Reason for Referral: _____

History: _____

*** Please attach any clinical notes, investigations, etc. to support this request and expedite the referral process***

Diagnostic Tests Attached: X-Ray U/S CT/MRI NCS/EMG
 Other: _____ Pathology

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