Sunnybrook
HEALTH SCIENCES CENTRE

Drug Safety Clinic - Referral Form

2075 Bayview Avenue, Suite UG-00, Desk 1, TORONTO, Ontario, M4N 3M5
TEL (416) 480-6100, ext. 3061 FAX (416) 480-5229

N. H. Shear, MD, FRCPC — K. Binkley, MD, FRCPC
E. Weber, MD, FRCPC — L. Shapiro, MD, FRCPC
Carolyn Friedrich, Rebecca Johnson - Administrative Assistants — Jackie Campbell - Clinic Manager

Patient Name: _____DOB (YY/MM/DD): _____

Sex: _____ Health Card #: _____ Version Code:

Address: _____ Telephone: (H) _____(W) _____

Referring Doctor: _____**Billing #:** _____

Address: _____

Telephone #: _____ **FAX: _____**

Family Doctor: _____

Address: _____

Telephone #: _____ **FAX: _____**

Specify patient allergies or previous adverse drug reactions:_____

Onset of Reaction (YY/MM/DD): _____

Suspected Drugs / Products
Describe Adverse Reaction/Event – include date of reaction and timing in relation to drug/product
Additional information – Further details, laboratory values, treatment of reaction/outcome
Is this referral urgent? Provide details