

**Complete Form • ATTACH REQUIRED DOCUMENTS • Fax to: 905-521-8675****Patient Information:**

Last: _____ First: _____

Address: _____ City: _____ Province: _____ Postal Code: _____

Phone Number: _____

Health Card # or IFH or UHIP: _____

Date of Birth: _____
(year/mm/day)

Non-English patients – Language spoken: _____ Interpreter required: yes [] no []

Referring Physician: _____**Billing #:** _____

Address: _____ City: _____ Province: _____ Postal Code: _____

Phone Number: _____ Fax: _____

Family Doctor – if different from above: _____

Please attach the following with the SIS Clinic Referral Sheet:

- Positive HIV test result **required**
- Most recent CD4 and HIV viral load test result (if available)
- Genotype (if available)
- HCV genotype and HCV RNA (if applicable)
- Medication list **INCLUDING** the amount of HIV medication the patient has left
- Consult notes (if available)
- Other test results such as labs and diagnostic (if available)

*** If the patient is currently on HIV medication, please provide at least 30 days of medication for the patient.**

COMMENTS/NOTES: