HAMILTON URBAN CORE COMMUNITY HEALTH CENTRE
430 CANNON STREET EAST, HAMILTON, ON L8L2C8
Phone: 905-522-3233
Fax: 905-522-3706

SICKLE CELL DISEASE REFERRAL FROM

PATIENT INFORMATION

Last Name:		**First Name:**	**Date of Birth (dd/mm/yyyy):**
Street Address:			
City:		**Province:**	**Postal Code**
Phone (Home):		**Phone (Cell):**	**Phone (Work):**
Alternate Contact Name:		**Relationship:**	**Phone (Home/Cell):**
Referring Physician Name:	**Referring Physician Billing Number:**	**Referring Physician Phone:**	**Referring Physician Fax:**

MEDICAL INFORMATION

Health Card #:	**Version:**

Diagnosis:
Sickle Cell Disease

☐HbSS ☐β Thalassemia Major
☐HbSC ☐β Thalassemia Intermedia
☐HbS/β Thalassemia ☐HbH Disease
☐Other:_____

Patient informed of diagnosis.
☐Yes ☐No
Comments: _____

Other
Surgical History: ☐Yes ☐No
Comments: _____

Transfusion History: ☐Yes ☐No
Comments:_____

Allergies: ☐Yes ☐No
Comments:_____

Medications:

Interpretation services

Interpretation services needed: ☐Yes ☐No
If yes, please specify patient's primary language: _____

Reporting Provider Name (PRINT)	Signature	Date

Note: Please return completed form to us via Fax: 905-522-3706 or Email: intakes@hucchc.com