Lennox & Addington County General Hospital

TRANSFUSION/INFUSION CLINIC REFERRAL
(Interim)

PLEASE FAX TO: (613) 354-8244

PATIENT INFORMATION:

Name:	Phone:
OHIP:	Alternate Phone:
Address:	

INFUSION/TRANSFUSION (Please check appropriate boxes)**:**

- ☐ Red blood cell transfusion
- ☐ Platelet transfusion
- ☐ Albumin infusion
- ☐ Medication (specify dose/frequency below)
- ☐ IVIG
- ☐ IV fluids
- ☐ Iron infusion
- ☐ Phlebotomy

INDICATION(S):

CURRENT MEDICATIONS (or attach list)**:**

ALLERGIES:

LABWORK (within 30 days)**:**

- ☐ Pending
- ☐ Attached
- ☐ Available on Connecting Ontario

REFERRING CLINICIAN INFORMATION:

Name:	Phone #:
Billing # CPSO:	Fax #:
Address:	
Clinician Signature:	