Ref: FAX-MSG-1026

ASN SPECIALIST REFERRAL FORM

Aafiyat Rapid Access to Specialists (ARAS) | One form for all services

Mississauga: 80-3465 Platinum Drive | Brampton: Unit B7-B8, 10910 Dixie Rd | Kitchener: 150 Duke St W
Tel/Text/WhatsApp (289) 813-0786 | Mon-Fri 9 am-9 pm, Sat-Sun 10 am-6 pm | www.aafiyat.ca

FAX COMPLETED REFERRALS TO: (844) 614-2845 Questions: (289) 813-0786

1. PATIENT INFORMATION

Patient name (Last, First): _____ DOB (YYYY-MM-DD): _____

Health card #: _____ Version: _____ Sex: ☐ M ☐ F ☐ X / other

Phone: _____ Alt. phone / email: _____

Address: _____

Parent/guardian (if pediatric): _____ Language: ☐ English ☐ Other: _____

2. SERVICE REQUESTED (CHECK ALL THAT APPLY)

SPECIALTY CLINICS
- ☐ Internal Medicine
- ☐ Nephrology (via IM)
- ☐ Endocrinology
- ☐ Neurology
- ☐ Geriatrics (home visit? Y / N)
- ☐ Physiatry / Pain / MSK
- ☐ Cardiology
- ☐ Skin Care
- ☐ IV Iron Infusion *

PEDIATRICS
- ☐ General Pediatric Consult
- ☐ Newborn / Neonatal Assessment
- ☐ Developmental & Behavioural
- ☐ ADHD / Pediatric Mental Health
- ☐ Asthma / Eczema / Allergy
- ☐ Circumcision *

WOMEN'S HEALTH
- ☐ Contraception (IUD/Nexplanon)
- ☐ Menopause / Perimenopause
- ☐ Breastfeeding / Lactation
- ☐ Cervical Cancer Screening

LIFESTYLE MEDICINE
- ☐ Weight Management
- ☐ Nutrition & Exercise *
- ☐ Travel Medicine *

Other / specific physician requested: _____ ** Private pay / insurance*

Preferred location: ☐ First available ☐ Mississauga ☐ Brampton ☐ Kitchener

3. CLINICAL DETAILS

Clinical concern / diagnosis: _____

_____

Specific question for consultant: _____

Current medications / allergies: _____

Attached: ☐ Recent labs ☐ Imaging ☐ Medication list ☐ Consult notes ☐ Discharge summary ☐ Growth charts

Urgency: ☐ Urgent (within 1 week) ☐ Semi-urgent (2-4 weeks) ☐ Routine ☐ Second opinion

For emergencies, please direct the patient to the nearest emergency department. Urgent referrals: please also call (289) 813-0786.

4. REFERRING PROVIDER

Name: _____ CPSO / CNO #: _____

OHIP billing #: _____ Clinic name: _____

Phone: _____ Fax (for consult note): _____

Signature: _____ Date (YYYY-MM-DD): _____

Once received, Aafiyat contacts the patient directly to book, and faxes the consult note back to you.
All referral forms: www.aafiyat.ca/refer | Aafiyat Medical Centre | www.aafiyat.ca

CONFIDENTIAL: Contains personal health information (PHIPA). If received in error, notify Aafiyat Medical Centre at (289) 813-0786 and destroy all copies.