Perth and Smiths Falls District Hospital

Patients and Families THE Heart OF Care

Out Patient Services Referral Form

Smiths Falls Site: **Fax: (613) 283-3659**
GWM Site: **Fax: (613) 267-7618**

Name: _____

Address: _____

City: _____ Postal Code: _____

Telephone: _____

Alternate or work#: _____

Family Physician: _____

HIN:_____ DOB: _____

Please check off the appropriate service and site Z# _____

Smiths Falls Site Tel: 613 283 2330		**Great War Memorial Site 613-267-1500**	
☐	Physiotherapy – ext 2116	☐	Dietician – ext 4221
		☐	Occ. Therapy – ext 4212
		☐	Physiotherapy – ext 4275
		☐	Speech Therapy – ext 4268

Referring Physician _____/_____
(signature) (print please)

Physician Referring No: _____ Date: _____

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Reason for Referral:

Relevant Diagnostic Tests