Hamilton Health Sciences

Special Immunology Services (SIS) Clinic Referral Form
www.hamiltonhealthsciences.ca/sis

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

Patient Information – Name, Address, DOB – print clearly or affix label

Last: **First:**

Apt.: **Address:** **City:**

Prov.: **Postal Code:** **PH: home:** **cell:**

Health Card # or IFH or UHIP:

Date of Birth:
(dd/mmm/yyyy)

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

Referring Physician PRINT CLEARLY: **Billing #:**

Address:

City: **Prov.:** **Postal Code:**

PH: **Fax:**

Family Doctor – if different than referring:

Please attach the following with the SIS Clinic Referral Sheet:
**Positive HIV test result ** required **
Most recent CD4 and HIV viral load result (if available)
Genotype (if available)
HCV genotype and HCV RNA (if applicable)
Medication list
Consult notes (if available)
Other test results e.g. urine, x-ray, etc. (if available)
***if the patient is on any medication and is moving to this area, please ensure that a three month supply is provided.**

COMMENTS/NOTES:

TO BE COMPLETED BY SIS CLINIC:

Please inform the patient that the first appointment will be on:_____ with the

Social Worker at _____ am/pm and Nurse at _____ am/pm. Lab work will also be completed. This appointment will be approximately 3 hours in duration.

The second appointment with one of the SIS Physicians will be booked at a later date (typically within a month of the first appointment) and the details will be provided at the first appointment.

The SIS Clinic is located at The Hamilton General Hospital, 237 Barton St E, Department 2E. Hamilton ON L8L 2X2. There are parking facilities located around the hospital. (there will be a charge for this). **If the patient is unable to attend this appointment, please have them call (905) 521-5075 to reschedule.**

Please instruct patient to bring ALL medications to ALL appointments.

Completed by: Faxed on: