Hamilton Health Sciences

Special Immunology Services (SIS Clinic)
690 Main Street West Hamilton, Ontario
L8S 1A4

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

Patient Information:

Last: _____ First: _____

Address:_____ City: _____ Province: _____ Postal Code: _____

Phone Number:_____

Health Card # or IFH or UHIP: _____

Date of Birth: _____
(year/mm/day)

Non-English patients – Language spoken: _____ Interpreter required: yes ☐ no ☐

Referring Physician:_____ **Billing #:**_____

Address:_____ City:_____ Province: _____ Postal Code:_____

Pone Number:_____ Fax:_____

Family Doctor – if different from above: _____

Please attach the following with the SIS Clinic Referral Sheet:

- Positive HIV test result ** required ** ☐
- Most recent CD4 and HIV viral load test result (if available) ☐
- Genotype (if available) ☐
- HCV genotype and HCV RNA (if applicable) ☐
- Medication list **INCLUDING** the amount of HIV medication the patient has left ☐
- Consult notes (if available) ☐
- Other test results such as labs and diagnostic (if available) ☐

*** If the patient is currently on HIV medication, please provide at least 30 days of medication for the patient.**

COMMENTS/NOTES: