

# PLASTIC SURGERY CONSULTATION REFERRAL FORM

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Plastic, Reconstructive and Aesthetic Surgery  
Staff Surgeon, Humber River Hospital

Preferred Location:  Toronto Humber Office  
➤ 1017 Wilson Ave, Suite  
104, Toronto ON  
 Brampton Office  
➤ 2250 Bovaird Dr. E, Suite  
303 Brampton ON

## REASON FOR REFERRAL (please specify):

- Breast Complaint (ie. breast hypertrophy, breast reconstruction)
- Upper extremity (ie. hand/wrist trauma, carpal tunnel syndrome or other nerve problem, arthritis, Dupuytren's, wrist pain)
- Skin cancer (ie. BCC, SCC, melanoma etc)
- Lump and Bump Clinic (ie. Lipomas, sebaceous cysts, pigmented lesions)
- Aesthetic Surgery (ie. Breast augmentation, abdominoplasty, blepharoplasty)
- Other: \_\_\_\_\_

**\*\* PLEASE INCLUDE ALL RELEVANT MEDICAL REPORTS WITH THIS REFERRAL \*\***

**\*\* PLEASE INSTRUCT PATIENT TO BRING A CD WITH ALL XRAY, CT OR MRI IMAGES \*\***

**\*\* FOR WORK INJURIES, PLEASE ENSURE PATIENT BRINGS WSIB FORMS AND CLAIM NUMBER\*\***

## PATIENT INFORMATION (or label):

Name: \_\_\_\_\_  
Last First

Date of Birth: \_\_\_\_\_  Male  Female  
DD / MM / YYYY

Address: \_\_\_\_\_  
Street # Street Name City Province Postal Code

Phone: \_\_\_\_\_ Alternate: \_\_\_\_\_

OHIP: \_\_\_\_\_  
10 Digit # Version Code

## REFERRED BY (Or stamp) :

Name: \_\_\_\_\_ Physician #: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## CONTACT INFORMATION:

Please **FAX** all referrals to: (888) 610-5439

For any questions please call my office: (647) 946-5439

Thank you for the referral.