Referral to

Second Radiology
563 Eglinton Ave. West
Toronto, ON M5N 1B5
Phone: 416-551-7700
Fax: 647-689-2012

SECOND RADIOLOGY
YOU DESERVE A SECOND OPINION

Patient's Information

Name _____

Address _____

Contact Number _____

Health Card Number _____

Date of Birth _____

Reason for Referral _____

_____

_____

Clinical History _____

_____

_____

Medical Imaging Information

Body Area of Diagnostic Study _____

Date of Diagnostic Study _____

Diagnostic Facility Used _____

Attach the original radiology report you are seeking a second opinion on, plus any other relevant imaging documents

Referring MD

Name _____

Address _____

Telephone Number _____

Fax Number _____

OHIP Billing Number _____

Signature _____

Once complete, please fax to 647-689-2012