



Influenza Assessment Clinic Referral

Fax: 709-752-4732



Name: _____

HCN: _____

Date of Birth: _____

Date: DD/MONTH/YYYY

Patient Information:

Telephone Numbers: (Home) _____ (Cell) _____ (Work) _____

Street Address/Box Number: _____

City/Town: _____ Postal Code: _____

Referring Physician Information:

Address: _____

Telephone: _____ Fax: _____ Postal Code: _____

Physician's Name: _____ Physician's Signature: _____

Reason for Referral: (For appropriate triage and booking, include patient medications, relevant tests and history.)