Winnipeg Regional Health Authority | Office régional de la santé de Winnipeg
Caring for Health | *À l'écoute de notre santé*

Request for Consultation/Referral

Date: D D M M M Y Y Y Y

Client Health Record #
Client Surname
Given Name
Date of Birth
Gender
MFRN
PHIN
Address

I have discussed this referral with the client/client's representative and have received approval to proceed with the referral and the sharing of personal health information or personal information for the purpose of the referral.

To Program/Service: _____

Reason for Consultation/Referral:

Referring Site/Program: _____

Signature _____ Printed Name and Designation _____ Date: D D M M M Y Y Y Y