DR. JUSTIN KHETANI, MD FRCSC
Otolaryngology · Head & Neck Surgery · Rhinology

REFERRAL FAX (905) 639-2253
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Referral *for physicians and nurse practitioners*

Please mark the urgency and attach any imaging report, prior consultation notes and the medication list. Your own EMR referral template is equally welcome; this form is a convenience, not a requirement.

URGENCY (mark one; the first line of the referral is read first)

☐ Routine ☐ Expedited: nasal polyps confirmed on CT (report attached) ☐ Urgent: unilateral or atypical findings

☐ Other urgent: _____

Emergencies go to the emergency department, not by fax: orbital swelling or visual change with sinusitis, uncontrolled epistaxis, a suspected septal hematoma or abscess, a recent nasal fracture, or clear watery rhinorrhoea after injury or surgery.

1 PATIENT

Last name | First name | Date of birth (YYYY-MM-DD) | Sex

Health card number | Version | Telephone (primary) | Telephone (alternate)

Address | Email (optional)

May the office leave a voicemail? ☐ Yes ☐ No Interpreter / accessibility needs: _____

2 REFERRING CLINICIAN

Name | Billing number | CPSO / CNO number | Date of referral

Clinic name and address | Telephone | Fax (for the consultation note)

Signature

A consultation note is sent to the fax number above after the visit.

3 REASON FOR REFERRAL (MARK ALL THAT APPLY)

☐ Nasal obstruction side: L R both
☐ Recurrent acute sinusitis per year: ____
☐ Septal perforation
☐ Assessment for biologic therapy
☐ Chronic rhinosinusitis without polyps
☐ Loss or distortion of smell onset: _____
☐ Nasal deformity with breathing problem
☐ Other: _____
☐ Chronic rhinosinusitis with nasal polyps
☐ Hearing loss or tinnitus
☐ Recurrent epistaxis

Duration of the problem

Brief history, treatment already tried, and what you would like assessed

4 INVESTIGATIONS

☐ CT sinuses done — date / site: _____ ☐ report attached ☐ not done (not required to refer)
☐ Allergy testing (results attached) ☐ Sleep study ☐ Previous otolaryngology consultation (notes attached)
☐ Previous nasal or sinus surgery — year and procedure: _____ ☐ operative report attached

5 RELEVANT HISTORY (MARK ALL THAT APPLY)

☐ Asthma
☐ Immunosuppression
☐ Diabetes
☐ Previous nasal injury
☐ Aspirin / NSAID sensitivity
☐ Bleeding disorder
☐ Smoking or vaping
☐ Sleep-disordered breathing / OSA
☐ Allergic rhinitis
☐ Anticoagulant / antiplatelet: _____
☐ Pregnancy or breastfeeding
☐ Other: _____

This form contains personal health information. Fax only to (905) 639-2253. If received in error, please notify the office and destroy the document. Referrals are triaged by urgency and completeness; the office contacts the patient directly to book, and sends a consultation note to the referring clinician after the visit.

Form v5.0 · September 2026