

Mississauga Health Cough & Flu Clinic

2695 North Sheridan Way Suite #120

Mississauga, ON L5K 2N6 Phone: 905-361-1448 Fax: 905-785-8360

This clinic will see patients who screen positive for symptoms compatible with COVID-19 and provide assessment, testing and treatment as required. We do not see asymptomatic patients. We do not see patients younger than 1 year old.

PLEASE INCLUDE THE MOST UP TO DATE CONTACT INFORMATION FOR PATIENT

PLEASE ALSO INCLUDE A COPY OF THE PATIENT'S CPP IF AVAILABLE

| |
|---------------------------|
| NAME: _____ |
| DOB: _____ |
| PREFERRED CONTACT#: _____ |
| HEALTH CARD#: _____ |

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|---|
| PLACE PATIENT LABEL HERE WITH MOST UP TO DATE INFORMATION |
|---|

Check all that apply:

- | | |
|---|---|
| <input type="checkbox"/> Fever of 37.8 degrees or higher | <input type="checkbox"/> Runny nose, sneezing or nasal congestion |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Sore throat and/or pain swallowing |
| <input type="checkbox"/> Cough (new or worsening) | <input type="checkbox"/> Change or loss of sense of taste/smell |
| <input type="checkbox"/> Nausea/Vomiting, diarrhea, abdominal pain | <input type="checkbox"/> Chills |
| <input type="checkbox"/> Headache (unrelated to other known causes) | <input type="checkbox"/> Fatigue, lethargy, malaise |
| <input type="checkbox"/> Myalgias | <input type="checkbox"/> Decreased or lack of appetite |

Additional Comments:

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IMPORTANT INFORMATION NEEDED TO COMPLETE REFERRAL:

PROVIDERS FULL NAME: _____ Billing # _____

OFFICE PHONE: _____ BACKLINE or CELL PHONE _____

Fax: _____

OFFICE ADDRESS: _____

