CAMBRIDGE MEMORIAL HOSPITAL

REQUEST FOR PATIENT INFORMATION (Circle of Care)

Date:

Requestor Name/Organization:

Requestor Telephone:

Requestor Fax Number:

Patient's Full Name:

Date of Birth:

Health Card Number:

Approximate date of Visit:

Please Mark Information Required:

☐History & Physical ☐Consultation Report ☐Operative Report ☐Discharge Summary

☐Emergency Report ☐ Laboratory Reports ☐Diagnostic Imaging

☐Cardiorespiratory (circle): ECG, Echo, Stress Test, Holter Monitor, Pulmonary Function Test

☐ Progress Note ☐ Psychiatric Notes ☐ Orders

☐Other

Timeline Required (please indicate): ☐Urgent ☐4 hours ☐24 hours ☐48 hours

Contact Information:
Release of Information Hours: Monday to Friday 7:00 am to 5:00 pm
Fax Number: 519-740-4958

Emergency Department: Sunday to Saturday- 5:00 pm to 7:00 am
Fax Number: 519-740-4921