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## PATIENT TRANSFER NOTIFICATION FORM FOR POTENTIAL ORGAN / TISSUE DONORS

<b>PATIENT'S NAME</b>	
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<b>Date of Birth</b>	_____ / _____ / _____ (dd) (mm) (yyyy)
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<b>O.H.I.P #</b>	_____ <b>Version Code:</b> _____
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Next-of-Kin (Name)	Relationship to the Patient

	Next of Kin's Mailing Address	Patient's Mailing Address
Address 1		
Address 2		
City/Province		
Postal Code		

<b>Referring Physician:</b>	
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<b>FORM TO BE FAXED TO RECEIVING HOSPITAL</b>	
	<b>Fax:</b>