NORTH YORK GENERAL
Making a World of Difference

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Paediatric Ambulatory Clinic REFERRAL FORM

FORM PS284 **Page 1 of 1** **Rev. 10/2020**

Patient LABEL / Identification Area

Patient Name: _____ **Today's Date:** _____

APPOINTMENT TYPE REQUESTED? ☐ In-person ☐ Virtual - Email: _____

REFERRAL TO: ☐ **General Paediatric Consultation Clinic**

Appointment if pre-booked: (**URGENT** appointments only) Date: _____Time: _____	Referral urgency if not pre-booked: ☐ Urgent < 1 week ☐ Semi-urgent 1-2 weeks ☐ Non-urgent
☐ The patient does not have a primary care provider ☐ The patient does have a primary care provider ☐ Not available ☐ Need paediatric opinion ☐Request second opinion	

REFERRAL TO PAEDIATRIC SUBSPECIALTY CLINICS:

- ☐ **Paediatric Dermatology Clinic**
- ☐ **Paediatric Neurology Clinic**
- ☐ **Paediatric Gynecology Clinic**
- ☐ **Paediatric Respirology/Asthma Clinic**
- ☐ **Paediatric Gastroenterology Clinic**
- ☐ **Paediatric Rheumatology Clinic**
- ☐ **Bowel and Bladder Dysfunction/Constipation Clinic**

For online referral forms and more information please visit http://www.nygh.on.ca/paedsreferrals/

REASON FOR REFERRAL:

Please fax relevant documents (lab results, diagnostic imaging, growth charts, etc.) to 416-756-6152

REFERRING HEALTHCARE PROVIDER INFORMATION:

Name:	**Billing #:**
Telephone number:	**Fax number:**
Address:	