Patient Label / Identification Area  

Paediatric Ambulatory Clinic  
REFERRAL FORM  

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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 Respiratory/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: ___________________________

Approved by: Paediatrics Program, Forms Working Group  Approval Date: October 2020 (archive: N/A)