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Paediatric Clinic REFERRAL FORM

FORM PS284 Page 1 of 1 Rev. 08/2022

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:	Referral urgency if not pre-booked:
(URGENT appointments only)	☐ Urgent < 1 week ☐ Semi-urgent 1-2 weeks
Date:Time:	□ Non-urgent
☐ The patient does <u>not</u> 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:	
☐ Bowel and Bladder Dysfunction/Constipation Clinic	
☐ Paediatric Dermatology Clinic ☐ F	Paediatric Nephrology Clinic
□ Paediatric Gastroenterology Clinic □ Paediatric Respirology/Asthma Clinic	
☐ Paediatric Gynecology Clinic ☐ F	Paediatric Rheumatology Clinic
Online referrals accepted via Ocean eReferral	
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:	