PEDIATRIC AMBULATORY CLINICS – MUMC REFERRAL FORM

Acquired Brain Injury (Head Injury), Asthma/Allergy, Child Advocacy and Assessment Program, Gastroenterology, Hemophilia, Hematology/Oncology, Nephrology, Neurology, Neurosurgery, Respirology, Spina Bifida, Thrombophilia.

3F Clinic Fax (905) 521-2654

REFERRAL REQUEST TO: __________________________ (Specialty- must be included) ___________________________ (Physician)

*****ACCURATE AND LEGIBLE COMPLETION OF THE REFERRAL FORM IS ESSENTIAL*****

REFERRING PHYSICIAN INFORMATION:	**PATIENT INFORMATION:**
NAME:	NAME: M☐ F☐
ADDRESS:	ADDRESS:
POSTAL CODE:	POSTAL CODE:
TEL#:	TEL#:
FAX#:	PARENT/GUARDIAN'S NAME: ________________________________
EMAIL (optional):	
PHYSICIAN BILLING #: ________________	HEALTH CARD #: ____________________ (Please include Version Code)

FAMILY HAS BEEN MADE AWARE OF THIS REFERRAL: ☐YES ☐NO

PLEASE CALL THE PHYSICIAN DIRECTLY IF THIS REQUEST IS URGENT

REASON FOR REFERRAL:

BRIEF HISTORY: (PLEASE ATTACH RESULTS OF INVESTIGATIONS RELEVANT TO THIS REFERRAL)

MEDICATIONS:

Physician Signature: ____________________

CLINIC USE ONLY

Referral Received by:____________________ **date:**__________________**dd/mm/yy**

Clinic and Clinician Assigned to for triage: ____