McMaster Children's Hospital – RJCHC Site
Developmental Pediatrics & Rehabilitation Program
237 Barton Street East, Hamilton, ON L8L 2X2
Phone: (905) 521-7950 Fax: (905) 577-8029

Referral Form - Professional

Date of Request YY MM DD **Girl** ☐ **Boy** ☐

Child's Name: LAST NAME FIRST NAME

Date of Birth: YY MM DD **Health Insurance Number** **Version Code**

Address:

City: **Postal Code:**

Name of mother (or foster/adoptive/step mother):
Home phone: **Cell phone:**

Name of father (or foster/adoptive/step father):
Home phone: **Cell phone:**

Name of legal guardian if it is not the parents:
Phone:

What is the best way/time to reach the parent(s)?

Is an interpreter required? If 'yes', language spoken:

Reason for Referral: (Please describe the concerns for this client. Include any relevant documentation.)

Is the child receiving any other services at the RJCHC (e.g. SLP, SW, OT, PT):

Other professionals/services currently involved (e.g. CAS/CCAS, Early Words):

Other relevant diagnoses or conditions, allergies:

Relevant medical/psychiatric/safety concerns regarding the family:

Family Physician: **Phone:**

Additional Comments:

Referral Source name & address:	**Signature:**
Phone: **Email:**	**Fax:**

Physician's OHIP Billing Number: (if applicable) **Physician's Signature:**

OHIP regulations stipulate that requests for physician consultations must be provided in writing by a physician