PEDIATRIC AMBULATORY CLINICS REFERRAL FORM

Consulting Pediatrics

2G Clinic Fax (905) 521-5056

REFERRAL REQUEST TO: _____

(Physician – NOTE: may be triaged to an alternate team physician based on wait times**)**

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

REFERRING PHYSICIAN INFORMATION:

NAME:

ADDRESS:

POSTAL CODE:

TEL#:
FAX#:

EMAIL:

PHYSICIAN BILLING #: _____

PATIENT INFORMATION:

NAME: **M☐ F☐ Other_____**

ADDRESS:

POSTAL CODE:
E-MAIL ADDRESS:
TEL#:
PARENT/GUARDIAN'S NAME:
_____

HEALTH CARD #:_____
(Please include Version Code)

Has the family been made aware of this referral? **☐No ☐Yes**

Does this patient have a community pediatrician? **☐No ☐Yes, have the pediatrician refer the patient**

PLEASE CALL THE PHYSICIAN DIRECTLY IF THIS REQUEST IS URGENT

REASON FOR REFERRAL:

BRIEF HISTORY: (please attach results of investigations, growth charts & other assessments relevant to this referral)

MEDICATIONS:

ALLERGIES:

Physician Signature: _____

CLINIC USE ONLY

Referral Received by:_____ **Date:**_____**dd/mm/yy**

Clinic and Clinician Assigned to for triage: _____