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
www.mcmasterchildrenshospital.ca/dpr

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