

PEDIATRIC INFECTIOUS DISEASES REFERRAL

Contact booking desk at **905-521-2100 x 73861** for any further questions

Date of Referral:

Please fax completed forms to:

905-521-2654

Patient Information	Referring Physician Information
Name:	. Name:
DOB:MaleFemale	
Health Card # (OHIP)	
Address:	Telephone:
City: Postal Code:	Fax:
Telephone: Cellular: Interpreter required:	_ Physician Billing #:
CAS/FACS involvement:Family Physician:	Signature:
REASON(S) FOR CONSULTATION (Please in	ndicate the specific question and all relevant details)
Please attach ALL supporting information (Please select	• • • •
□ Last clinical letter □ Blood work □ Vaccine record □ Swab results	☐ MRI/CT reports☐ Stool sample results☐ X-ray reports
Other:	
De distuis Infestion	us Diseases Office Hee Only
ID physician Notes:	us Diseases Office Use Only
□ Blood work	🗆: X-ray
□ MRI	
□ Visit:	
Triage Dr: PERNICA WONG	□ OTHER
Received: Triage Date:	U#M