

PEDIATRIC SPECIAL IMMUNIZATION REFERRAL

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

Please fax completed forms to:

905-521-2654

Date of Referral: _____

Patient Information	
Name:	_____
DOB:	_____ Male _____ Female
Health Card #	_____ (OHIP)
Address:	_____
City:	_____ Postal Code: _____
Telephone:	_____ Cellular: _____
Interpreter required:	_____
CAS/FACS involvement:	_____
Family Physician:	_____

Referring Physician Information	
Name:	_____
Address:	_____
Postal Code:	_____
Telephone:	_____
Fax:	_____
Physician Billing #:	_____
Signature:	_____

REASON(S) FOR CONSULTATION *(Please select all that apply)*

- | | |
|---|--|
| <input type="checkbox"/> Vaccine reaction | <input type="checkbox"/> Bone marrow transplant |
| <input type="checkbox"/> Vaccine hesitancy | <input type="checkbox"/> Other immunodeficiency (non-transplant) |
| <input type="checkbox"/> Sickle cell disease or haemoglobinopathy | <input type="checkbox"/> Vaccine catch up schedule |
| <input type="checkbox"/> Travel | <input type="checkbox"/> Other |
| <input type="checkbox"/> Pre splenectomy (surgery date required) | _____ |
| <input type="checkbox"/> Post splenectomy | _____ |
| <input type="checkbox"/> Solid organ transplant | |

Details of Referral *(frequency of symptoms, other signs and symptoms):*

Medications: _____

Please attach ALL supporting information *(Please select all that apply):*

- Last clinical letter
- Vaccine record (required)
- Other: _____

Pediatric Infectious Diseases Office Use Only

ID physician Notes: _____

- _____
- _____
- _____
- _____

MFPEDSPIMM

Triage Dr: ABDURRAHMAN PERNICA