PEDIATRIC INFECTIOUS DISEASES REFERRAL

McMaster Children's Hospital

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 indicate the specific question and all relevant details)*

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

□ Last clinical letter □ Blood work □ MRI/CT reports □ Stool sample results

□ Vaccine record □ Swab results □ X-ray reports

□ Other: _____

Pediatric Infectious Diseases Office Use Only

ID physician Notes: _____

_____

_____

_____

□ Blood work _____ □: X-ray _____

□ MRI _____ □ _____

□ Visit: _____

□ MFPID

Triage Dr: □ PERNICA □ WONG □ OTHER

Received: _____ Triage Date: _____ U#M_____