PEDIATRIC SPECIAL IMMUNIZATION 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 select all that apply)*

□ Vaccine reaction
□ Vaccine hesitancy
□ Sickle cell disease or haemoglobinopathy
□ Travel
□ Pre splenectomy (surgery date required)
□ Post splenectomy
□ Solid organ transplant
□ Bone marrow transplant
□ Other immunodeficiency (non-transplant)
□ Vaccine catch up schedule
□ Other

_____

_____

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