Ron Joyce Children's Centre
237 Barton Street East, Hamilton, ON L8L 2X2
Phone: (905) 521-2100 Ext. 47575
Fax: (905) 577-8029

Spina Bifida Clinic – Referral Form

Date of Request:	DD MM YY	**Female:** ☐	**Male:** ☐
Child's Name:	LAST NAME	FIRST NAME	
Date of Birth:	DD MM YY	**Health Insurance Number:**	
Address:			
City:		**Postal Code:**	
Name of Mother (or other legal guardian):			
Phone:		**Email:**	
Name of Father (or other legal guardian):			
Phone:		**Email:**	
What is the best time of day to reach Parent/Guardian?			
Interpreter required?	**Yes** ☐ **No** ☐	**Language Required:**	
Reason for Referral: (Please describe the concerns for this client. Include any relevant documentation)			
Is this child receiving any other service at the RJCHC? (e.g.. SLP, SW, OT, PT)			
Other professionals/services currently involved? (e.g. CAS, Urology, Neuro)			
Other relevant diagnosis's, conditions or allergies:			
Relevant medical, psychiatric, safety concerns regarding family?			
Family Physician:		**Phone:**	
Additional Comments:			

Referral Physician:	**Signature:**
Phone:	**Stamp:**
Fax:	
Email:	
Physician OHIP Billing Number:	

OHIP regulations stipulate that requests for physician consultations must be provided in writing by a physician