Hamilton Health Sciences

Special Immunology Services (SIS Clinic)
690 Main Street West Hamilton, Ontario
L8S 1A4

Must complete all fields with to minimize delays on the referral of your patient. Fax to 905 521 8675

Child's Last Name: _____ Child's First Name: _____

Apt.:_____ Address: _____ City: _____

Prov.:_____ Postal Code: _____ Phone number:_____

Health Card # or IFH or UHIP: _____ Date of Birth: (dd/mmm/yyyy):_____

Name of Child's Birth Parent(s):_____

Name of Primary Care giver: _____

Name of Child's Service Worker (if applicable):_____

Person to Notify of Drs appt and Phone number:_____

Non-English patient/Care giver- Language spoken: _____ Interpreter required: yes ( ) no ( )

Referring Physician/Agency: _____ Billing #:_____

Address: _____ City:_____ Prov.:_____ Postal Code:_____

Please attach the following with the SIS Clinic referral Sheet:

For HIV Positive Children:

*Positive HIV test ☐

*Most recent CD4 and HIV Viral load results ☐

*List of medications all meds (specially ARVs)

*HCV RNA and genotype (if applicable) ☐

*Notes on Surgeries, learning and developmental issues and opportunistic infections, antiretroviral history and reason for any changes ☐

For Children of High risk mom mothers:

*HIV PCR, HIV serology/P24 antigen at birth ☐

*List of Medications (Antiretroviral) ☐

*Mother's HIV PCR or serology, Syphilis, Hepatitis B & C results ☐

*Was baby given antiretrovirals? If yes which one? ☐

*Significant neonatal events (i.e. neonatal Opioid Withdrawal Syndrome) ☐

If patient is on any medication and is moving to this area, please ensure that a 3 month supply is provided

Special Considerations/Comments _____

_____

_____

Hamilton Health Sciences

Special Immunology Services (SIS Clinic)
690 Main Street West Hamilton, Ontario
L8S 1A4