McMaster Children's Hospital

PEDIATRIC AMBULATORY CLINICS REFERRAL

Patient's Last Name	First Name	
Address – Street	City	Postal Code
Date of Birth (yyyy/mm/dd) _____	Age _____	Gender ☐ M ☐ F
Health Card Number (please include version code)		
Parent / Guardian's Name:	Telephone:	

Referral Request to:

_____ CLINIC _____
(Specialty must be included)

Referral Date (yyyy/mm/dd) _____

Referring Physician (print) _____

Signature _____

Address _____

Telephone _____ **Fax** _____

Email (optional) _____ **Physician Billing Number** _____

Family has been made aware of this referral: ☐ Yes ☐ No

Interpreter Required: ☐ Yes – Language _____ ☐ No

Please call the physician directly if this request is urgent, through Paging at 905-521-2100 Ext. 76443

Reason for Referral: _____

_____

_____

_____

Brief History: (Please attach results of investigations relevant to this referral)

_____

_____

_____

_____

Medications: _____

_____

_____

_____

Please fax completed referral and accompanying documentation to the applicable clinic.

CLINIC USE ONLY

Referral Received by: _____ **Date:** (yyyy/mm/dd) _____

Clinical Clinician Assigned for the triage: _____

2G CLINIC – 905-521-2100

Clinic Ext. 78517
Fax: 905-521-5056

- Complex Care
- Cystic Fibrosis
- Diabetes
- Endocrinology
- General Pediatrics
- Neonatal Follow-up
- Nephrology
- Neurology
- Neurosurgery/Craniofacial
- Rheumatology
- RSV Clinic
- Urology

2Q CLINIC– 905-521-2100

Clinic Ext. 75094
Fax: 905-570-8958

- General Surgery
- Orthopedics

3F CLINIC– 905-521-2100

Clinic Ext. 73861
Fax: 905-521-2654

- Asthma / Allergy
- Hemophilia
- Hemoglobinopathy
- Hematology / Oncology
- Immunology
- Infectious Diseases
- Pediatric Burns
- Plastics
- PVA
- Quality of Life & Advanced Care
- Respirology
- Special Immunization
- Sweat Tests (Adult & Peds)
- Thrombophilia
- Young Women's Bleeding