NORTH YORK GENERAL

Paediatric Ambulatory Clinic
REFERRAL FORM

PS284

PATIENT INFORMATION

Last Name:

First Name

Date of Birth

OHIP #

Home Phone

Cell Phone

3rd Floor West, Room 369 4001 Leslie Street, Toronto, ON M2K 1E1 **nygh.on.ca**
T 416-756-6479 F 416-756-6152 E paeds.clinic@nygh.on.ca

Referral Date: _____

Interpreter needed: ❑ **No** ❑ **Yes**

Language: _____

REFERRAL TO:

General Paediatrics Consultation Clinic

- ❑ **Urgent Referral (1 - 2 days)**
- ❑ **Semi-Urgent Referral (1-2 weeks)**
- ❑ **Non-Urgent Referral**

REFERRAL TO:

- ❑ **Paediatric Gynaecology Clinic**
- ❑ **Paediatric Respirology / Asthma Clinic**
- ❑ **Paediatric Rheumatology Clinic**
- ❑ **Paediatric Nephrology Clinic**

REASON FOR REFERRAL: _____

Please attach blood & urine results, ultrasounds & X-Ray reports

REFERRING DOCTOR: _____ **Physician billing #** _____

Address: _____

Phone # _____ **Fax #** _____

PLEASE NOTE: Incomplete or illegible referrals will be returned to your office

Please fax this form to the Paediatric Ambulatory Clinic at 416.756.6152