NORTH YORK GENERAL
Making a World of Difference

4th Floor 4001 Leslie Street
Toronto ON M2K 1E1
Tel: 416-756-6479
Fax: 416-756-6152

Paediatric Clinic REFERRAL FORM

FORM PS284 **Page 1 of 1** **Rev. 01/2021**

Patient LABEL / Identification Area

Patient Name: _____ **Today's Date:** _____

APPOINTMENT TYPE REQUESTED? ☐ In-person ☐ Virtual - Email: _____

REFERRAL TO: ☐ **General Paediatric Consultation Clinic**

Appointment if pre-booked: (**URGENT** appointments only) Date: _____Time: _____	Referral urgency if not pre-booked: ☐ Urgent < 1 week ☐ Semi-urgent 1-2 weeks ☐ Non-urgent
☐ The patient does not have a primary care provider ☐ The patient does have a primary care provider ☐ Not available ☐ Need paediatric opinion ☐Request second opinion	

REFERRAL TO PAEDIATRIC SUBSPECIALTY CLINICS:

☐**Bowel and Bladder Dysfunction/Constipation Clinic**

☐ **Paediatric Dermatology Clinic** ☐ **Paediatric Respirology/Asthma Clinic**

☐ **Paediatric Gastroenterology Clinic** ☐ **Paediatric Rheumatology Clinic**

☐ **Paediatric Gynecology Clinic**

For online referral forms and more information please visit http://www.nygh.on.ca/paedsreferrals/

REASON FOR REFERRAL:

Please fax relevant documents (lab results, diagnostic imaging, growth charts, etc.) to 416-756-6152

REFERRING HEALTHCARE PROVIDER INFORMATION:

Name:	**Billing #:**
Telephone number:	**Fax number:**
Address:	