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:
☐ Adolescent Medicine Clinic ☐ Paediatric Gastroenterology Clinic
☐ Constipation/Dysfunctional Voiding Clinic ☐ Paediatric Neurology Clinic
☐ Paediatric Dermatology Clinic ☐ Paediatric Respirology/Asthma Clinic
☐ Paediatric Gynecology Clinic ☐ Paediatric Rheumatology 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:

<table>
<thead>
<tr>
<th>Name:</th>
<th>Billing #:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone number:</td>
<td>Fax number:</td>
</tr>
<tr>
<td>Address:</td>
<td></td>
</tr>
</tbody>
</table>

Approved By: Paediatrics Program, Forms Working Group   Approval Date: June 2019 (archive: N/A)