NORTH YORK GENERAL
Making a World of Difference

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Paediatric Ambulatory Clinic REFERRAL FORM

FORM PS284 **Page 1 of 1** **Rev. 06/2019**

Patient LABEL / Identification Area

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

Today's Date:

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**
☐ **Constipation/Dysfunctional Voiding Clinic**
☐ **Paediatric Dermatology Clinic**
☐ **Paediatric Gynecology Clinic**
☐ **Paediatric Gastroenterology Clinic**
☐ **Paediatric Neurology Clinic**
☐ **Paediatric Respirology/Asthma 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:

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