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 Toronto ON M2K 1E1  
 Tel: 416-756-6479  
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**Paediatric Ambulatory Clinic  
 REFERRAL FORM**

FORM PS284

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Rev. 06/2020

Patient LABEL / Identification Area

**Patient Name:** \_\_\_\_\_ **Today's Date:** \_\_\_\_\_

**APPOINTMENT TYPE REQUESTED:**

In-person  Virtual – Email address: \_\_\_\_\_

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

Appointment if pre-booked: (URGENT appointments only) Date: _____ Time: _____	Referral urgency if not pre-booked: <input type="checkbox"/> Urgent < 1 week <input type="checkbox"/> Semi-urgent 1-2 weeks <input type="checkbox"/> Non-urgent
<input type="checkbox"/> The patient does <u>not</u> have a primary care provider <input type="checkbox"/> The patient <u>does</u> have a primary care provider <input type="checkbox"/> Not available <input type="checkbox"/> Need paediatric opinion <input type="checkbox"/> Request second opinion	

**REFERRAL TO PAEDIATRIC SUBSPECIALTY CLINICS:**

- Paediatric Dermatology Clinic                       Paediatric Neurology Clinic
- Paediatric Gynecology Clinic                             Paediatric Respiriology/Asthma Clinic
- Paediatric Gastroenterology Clinic                     Paediatric Rheumatology Clinic
- Bowel and Bladder Dysfunction/Constipation Clinic

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

**REASON FOR REFERRAL:**

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

**REFERRING HEALTHCARE PROVIDER INFORMATION:**

<b>Name:</b>	<b>Billing #:</b>
<b>Telephone number:</b>	<b>Fax number:</b>
<b>Address:</b>	