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**Paediatric Clinic
 REFERRAL FORM**

FORM PS284

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Rev. 08/2022

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: <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:

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

Online referrals accepted via Ocean eReferral

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:	