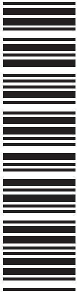

NORTH YORK GENERAL
Making a World of Difference

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. 09/2024**

Patient LABEL / Identification Area

Patient Name: ______________________ **Today's Date:** ____________

Caregiver or Patient Email address: ______________________

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

Appointment if pre-booked by NYGH:	Referral urgency if not pre-booked:
Date: ____________ Time: ________	☐ Urgent < 1 week ☐ 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

☐ Is there any significant medical or mental health complexity that would warrant a longer appointment slot?

Reason: ______________________

☐ **REFERRAL TO PAEDIATRIC SUBSPECIALTY CLINICS:**

- ☐ **Bowel and Bladder Dysfunction Clinic**
- ☐ **Paediatric Dermatology Clinic**
- ☐ **Paediatric Gastroenterology Clinic**
- ☐ **Paediatric Gynecology Clinic**
- ☐ **Paediatric Hematology Clinic**
- ☐ **Paediatric Nephrology Clinic**
- ☐ **Paediatric Respirology/Asthma Clinic**
- ☐ **Paediatric Rheumatology Clinic**

Online referrals accepted via Ocean eReferral

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:

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