



**Paediatric Clinic
REFERRAL FORM**

FORM PS284

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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 Hematology 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:	