PEDIATRIC AMBULATORY CLINICS – MUMC
REFERRAL FORM

Acquired Brain Injury (Head Injury), Asthma/Allergy, Child Advocacy and Assessment Program, Gastroenterology, Hemophilia, Hematology/Oncology, Nephrology, Neurology, Neurosurgery, Respirology, Spina Bifida, Thrombophilia.

3F Clinic Fax (905) 521-2654

REFERRAL REQUEST TO: _____ _____
(Specialty- must be included) **(Physician)**

*****ACCURATE AND LEGIBLE COMPLETION OF THE REFERRAL FORM IS ESSENTIAL*****

REFERRING PHYSICIAN INFORMATION:

NAME:

ADDRESS:

POSTAL CODE:

TEL#:
FAX#:

EMAIL (optional):

PHYSICIAN BILLING #: _____

PATIENT INFORMATION:

NAME: **M☐** **F☐**

ADDRESS:

POSTAL CODE:

TEL#:
PARENT/GUARDIAN'S NAME:
_____

HEALTH CARD #:_____
(Please include Version Code)

FAMILY HAS BEEN MADE AWARE OF THIS REFERRAL: ☐YES ☐NO

PLEASE CALL THE PHYSICIAN DIRECTLY IF THIS REQUEST IS URGENT

REASON FOR REFERRAL:

BRIEF HISTORY: (PLEASE ATTACH RESULTS OF INVESTIGATIONS RELEVANT TO THIS REFERRAL)

MEDICATIONS:

Physician Signature: _____

CLINIC USE ONLY
Referral Received by:_____ **date:**_____**dd/mm/yy**

Clinic and Clinician Assigned to for triage: _____