MICHAEL GARRON HOSPITAL
TORONTO EAST HEALTH NETWORK

General Paediatric Clinic Referral Form

Tel: 416-469-6590 Fax: 416-469-6591

(To register, please go to the Admitting Department)

REF

Patient Label

Patient Last Name: Given Name: Gender:		Date of Birth: (Day / Month / Year)
Address: Apt#:		Telephone Number - Home:
Town or City: Province: Postal Code:		Parent/Guardian's Telephone - Cellular:
Parent / Caregiver / Guardian: Relationship To Patient:		Parent/Guardian's Telephone - Work:
Family Physician / Paediatrician:		Other Parent/Guardian's Tel. - Cellular:
Ontario Health Card Number: Version Code	**Email Address For Virtual Consult (Telephone/Video):**	Other Parent/Guardian's Tel. - Work:

Required Questions:

INTERPRETER - Language interpreter required? ☐No ☐Yes - If YES, language:
- American Sign Language interpreter required? ☐No ☐Yes

PRIVACY - May we call the patient or leave a message? ☐No ☐Yes
If NO, who can we contact? Name: Tel:

Clinical Information:

Reason For Referral:

Allergies:

Medications:

History / Current Issues:

_____

_____

Relevant Past History / Family History:

_____

IMPORTANT PLEASE READ:

INCOMPLETE REFERRALS WILL BE RETURNED FOR COMPLETION

PLEASE SEND:

- **ALL PERTINENT DIAGNOSTIC & LAB RESULTS**
- **LIST OF CURRENT MEDICATIONS**
- **CONSULTNOTES / DISCHARGE SUMMARY**
- **INVESTIGATIONS**
- **GROWTH CHART**

Child and Teen Clinic Tel: 416-469-6590 **Fax: 416-469-6591**

☐ Adolescent Medicine Clinic ☐ Asthma / Chest ☐ Cardiology Clinic
☐ ECG ☐ Endocrine ☐ Healthy Lifestyle Clinic (Obesity Management)
☐ Neonatal Follow-up ☐ Paediatric Clinic ☐ Paeds/Adolescent Gyne Clinic
☐ Paediatric Clinic For Development Assessment
☐ Tongue Tie Release <1 month (>1 month refer to ENT)

Referring Physician:

Physician Name:	Telephone Number:	Fax Number:
Physician's Signature:	Billing#:	Date:

Appointment: