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:

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**

MGH ER Follow-up:

Urgent:
☐ 48-72 hr (direct-booking from ER)

Semi-urgent:
☐ 1-2 week (to be booked by paediatrician ONLY)

Non-urgent:
☐ Gen paeds (to be booked by paediatrician ONLY)

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

☐ Gen Paeds Consulting
☐ Newborn Assessment
☐ Development Assessment
- ○ Regional Neonatal Follow UP Clinic (0-36 months)
- ○ General Paeds Consulting Clinic (all ages)

☐ Tongue Tie Release
☐ Healthy Lifestyle Clinic (Obesity Management)
☐ Adolescent Medicine
☐ Paeds/Adolescent Gyne
☐ Cardiology
☐ Respirology (Asthma)
☐ Endocrinology (does not include Diabetes - refer to local Paediatric Diabetes Education Program)
☐ Nutrition Clinic
☐ Gastroenterology/Hepatology

Referring Physician:

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

Appointment: