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| • **(INCOMPLETE REFERRALS WILL BE RETURNED FOR COMPELETION)**•**Fax completed intake form to: (416) 867-3736**•**We will contact you and your patient with appointment date and time** •**Please note the booking process can take up to two weeks.****AVAILABLE ONLINE: www.unityhealth.to** |

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| **REFERRAL DATE:**  |
| **REQUESTED CLINIC: (Please select below)** |
| General Pediatric Clinic □ | Developmental Clinic □ | Adolescent Clinic □ |
| FASD Clinic □ | Hematology Clinic □ | Neonatal Follow-up clinic □ |
| Special Nutrition Clinic □ | Antenatal Clinic □ | Cardiology Clinic □ |
| Newcomer to Canada Clinic □ | Dermatology Clinic □ |  |
| **PATIENT INFORMATION** | **PLEASE CHECK IF URGENT** |
| MRN # \_**Last Name**:**First**:D.O.B. dd/mm/yyyy Age: Address:City: Prov: Postal: Contact #: OHIP #: IFH # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_OTHER INSURANCE #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **REFERRING PHYSICIAN** Referring Physician (please print) / Billing #AddressTelephone # / Fax #*SIGNATURE* |
| Previously Seen in this clinic: Yes ◌ No ◌ |
| **AGE CATEGORY (PLEASE CIRCLE)** |
| **NEWBORN****0-3 MOS** | **INFANT****3 – 12 MOS**  | **PRESCHOOL** **12-36 MOS** | **CHILD****3 – 12 YEARS** | **ADOLESCENT****13-18 YEARS** |
|  |
| -Language Interpreter Required? □ NO □ YES – if yes language \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ -American Sign Language Interpreter Required? □ NO □ YES- Does the patient have a regular family doctor? □ NO □ YES-**Newcomer to Canada Clinic**: Has patient been in Canada for less than 2 years? □ NO □ YES- Indicate all services already involved: □ Social Work □ Dietitian □ Other services: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **REASON FOR REFERRAL** |
|  |
| **PLEASE SEND:** |
| * **ALL PERTINENT DIAGNOSTIC & LAB RESULTS • LIST OF CURRENT MEDICATIONS • INVESTIGATIONS**

 **• CONSULT NOTES / DISCHARGE SUMMARY • GROWTH CHART • PREVIOUS RESOURCES**  |