ST. MICHAEL'S
UNITY HEALTH TORONTO

https://unityhealth.to/pedsclinicreferral

PEDIATRIC AMBULATORY CLINIC REFERRAL FORM

(Please fill in ALL sections)

PATIENT INFORMATION

Last Name: _____

First Name: _____

Middle Name: _____

Preferred Name: _____

Date of Birth: _____

Health Insurance:

- ☐ HCN: _____
- ☐ IFH: _____
- ☐ Private Insurance: _____
- ☐ None

Contact Number: _____

Address: _____

City: _____

Postal Code: _____

GENDER IDENTITY

- ☐ Female
- ☐ Male
- ☐ Other (non-binary, transgender)
- ☐ Prefer not to disclose

SPOKEN LANGUAGE

- ☐ English
- ☐ French
- ☐ Hearing Impaired. Language: _____
- ☐ Other: _____

REFERRING PROVIDER INFORMATION

Please select one of the following:

- ☐ Family Physician
- ☐ Pediatrician
- ☐ Nurse Practitioner
- ☐ Other

First Name: _____

Last Name: _____

Address: _____

City: _____

Postal Code: _____

Contact Number: _____

Fax Number: _____

Billing #: _____

Are you this patient's primary care provider?

☐ Yes ☐ No

If not, who is the primary care provider?

_____

PARENT/GUARDIAN INFORMATION

By listing telephone numbers or an e-mail address below, the referral source confirms that the patient consents for Unity Health to call or e-mail them regarding this referral. Unity Health will refrain from communicating unrequired personal information until consents are verified.

Primary Guardian's First Name: _____ Last Name: _____

DOB: _____ Preferred Phone Number: _____

Relationship to Patient: _____ Preferred Email: _____

☐ Address same as patient
Different address: _____

Caregiver has custodial rights ☐ Yes ☐ No Caregiver has medical decision making rights ☐ Yes ☐ No

Secondary Guardian's First Name: _____ Last Name: _____

DOB: _____ Preferred Phone Number: _____

Relationship to Patient: _____ Preferred Email: _____

☐ Address same as patient
☐ Different address: _____

Caregiver has custodial rights ☐ Yes ☐ No Caregiver has medical decision making rights ☐ Yes ☐ No

PLEASE SELECT THE FOLLOWING SERVICE YOU ARE SEEKING FOR YOUR PATIENT

Consulting Pediatrics (please choose one):

☐ Medical concern or ☐ Development

please write your reason in the provided box below

- ☐ ADHD
- ☐ ASD
- ☐ Behaviour (please specify below)
- ☐ School Problems

- If Development, please attach the following to your referral:
  - All previous assessments and reports
  - labs, audiology, imaging

☐ Adolescent Medicine – please specify concern:
- ☐ Mental Health
- ☐ Eating Disorder
- ☐ LGBTQ care
- ☐ Contraception/STI
- ☐ Other: _____

☐ Antenatal Consultation Clinic

☐ Pediatric Cardiology

☐ Pediatric Rheumatology

☐ Pediatric Dermatology **(**Please attach a list of current medications/treatments**)**

☐ Fetal Alcohol Spectrum Disorder (FASD) Diagnostic Clinic – is there documented prenatal alcohol exposure (PAE)?
- ☐ Yes ☐ No

*Please note the FASD clinic only sees children ages 6+; if under 6, you may consider referring for a development consultation if that would be beneficial in the interim.

☐ Pediatric General Hematology - attach labs and please specify reason below. (Referrals for Lymphadenopathy are not accepted.)

☐ Compass Clinic
- ☐ Newcomer to Canada (within last 5 years)
- ☐ Born in Canada or lived for >5 years + & requires additional system navigation/support
- ☐ First Nation, Inuit, or Métis

*Please note the Compass clinic does not offer primary care.

☐ Specialized Nutrition Clinic (MD & RD)
  - Sumac Creek (SMH FHT only)
  - 61 Queen Pediatric Clinic
- Please attach the following to your referral:
  - growth charts and labs
  - vitamins, supplements, medications
  - reports from OT/AB/feeding clinic

REASON FOR REFERRAL (REQUIRED FOR ALL REFERRALS)

Primary reason for referral must be indicated here (specify current symptoms, presenting problems and history):

Thank you for your referral to St. Michael's Pediatrics. Please note failure to include the requisite charts/reports may result in delays in booking. It is also important to note that we are ***not a crisis or emergency service***. Should your patient be in need of urgent support, please direct them to the nearest emergency department or call 911.

Completed by:

_____ (Print name) _____ Signature _____ dd/mm/yyy

- **INCOMPLETE REFERRALS WILL BE RETURNED FOR COMPLETION**
- Fax completed referral form to (416) 867-3736
- We will notify the patient of their appointment date and time
- Please note the booking process can take up to two weeks