ST. MICHAEL'S
UNITY HEALTH TORONTO

https://unityhealth.to/pedsclinicreferral

PEDIATRIC AMBULATORY CLINIC REFERRAL FORM

(Please fill in ALL sections)

PATIENT INFORMATION		PARENT/GUARDIAN INFORMATION	
Full Name (and preferred name + pronoun)		Full Name	
Date of Birth (DD-MM-YY)		Phone Number(s)	
Phone number(s)		Interpreter needed? ☐ YES (_____) ☐ NO	
OHIP/IFH number/Insurance number		Relationship to Patient: _____	
Address:		Email address:	

REFERRAL TO: (Please include additional documents i.e. bloodwork, growth charts, medications, reports, imaging, etc.)

General Pediatrics ☐	Fetal Alcohol Spectrum Disorder (FASD) 6+ years only ☐
Developmental Pediatrics (w/ relevant reports) ☐	Compass Clinic – Newcomer to Canada <5years, Indigenous (Consultation only. Not for primary care) ☐
Pediatric Hematology (with labs) ☐	Specialized Nutrition Clinic (with growth chart) ☐
Adolescent Medicine ☐	Pediatric Rheumatology ☐
Antenatal Consultation Clinic ☐	Pediatric Dermatology ☐
Pediatric Cardiology ☐	

REASON FOR REFERRAL (REQUIRED)

REFERRING PHYSICIAN	
Physician's Name	
Physician Billing Number	
Physician's Address	
Phone Number	
Fax Number	
Are you the patient's primary care physician?	☐ YES ☐ NO

COMPLETED BY:
(Print name)_____ Signature: _____ Date: _____

Thank you for your referral to St. Michael's Pediatrics. Please 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.

- **We now accept all types of referrals. However, use of our form allows for expedited triaging and booking.**
- Fax completed referral form to (416) 867- 3736. Incomplete referrals will be returned.
- We will notify the patient of their appointment date and time. Please note the booking can take up to two weeks