ST. MICHAEL'S
UNITY HEALTH TORONTO

PEDIATRIC AMBULATORY CLINIC REFERRAL FORM

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: ______________________

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 SERVICE YOU ARE SEEKING FOR YOUR PATIENT

- ☐ **General Consulting Pediatrics**
- ☐ Adolescent Medicine – please specify concern:
  - ☐ Mental Health
  - ☐ Eating Disorder
  - ☐ LGBTQ care
  - ☐ Contraception/STI
  - ☐ Other: ______________________
- ☐ Antenatal Consultation Clinic
- ☐ Pediatric Cardiology
- ☐ Developmental Pediatrics – is this a new assessment?
  - ☐ Yes ☐ No

  Please attach the following to your referral:
  - ☐ Previous assessments
  - ☐ Reports from SLP/OT/daycare/teachers
  - ☐ labs, audiology, imaging
- ☐ 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
- ☐ Pediatric Hematology - attach labs
- ☐ Compass Clinic)
  - ☐ Newcomer to Canada (within last 5 years)
  - ☐ Born in Canada or lived for >5 years + & requires additional system navigation, settlement/interpretation, advocacy, etc
  - ☐ 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/ABA/feeding clinic

REASON FOR REFERRAL

Please indicate the primary reason for referral (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