ST. JOSEPH'S
UNITY HEALTH TORONTO

PAEDIATRIC CONSULTATION CLINIC REFERRAL FORM

30 The Queensway, Toronto, ON M6R 1B5
Garron Family - Our Lady of Mercy Wing, 3rd Floor
Tel: 416-530-6625 Fax: 416-530-6294

DATE OF REFERRAL:_____

PATIENT INFORMATION	REFERRING PROVIDER INFORMATION
Last Name: _____ First Name: _____ Preferred Name: _____ Date of Birth: _____ (DD/MM/YEAR) Gender Identity: ☐ Female ☐ Male ☐ Other: _____ ☐ Prefer not to disclose Health Insurance: ☐ HCN: _____ ☐ IFH: _____ ☐ Private Insurance: _____ ☐ None: Phone Number: _____ Address: _____ Postal Code: _____	**Please select one of the following:** ☐ Family Physician ☐ Paediatrician ☐ Nurse Practitioner ☐ Other First Name: _____ Last Name: _____ Contact Number:_____ Fax Number: _____ Signature: _____ Billing Number: _____ **Are you this patient's primary care provider?** ☐ Yes ☐ No **If not, please provide name and contact information?** Name: _____ Phone Number: _____ Fax Number: _____

PARENT/GUARDIAN INFORMATION

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

Primary Guardian's First Name: _____ **Last Name:** _____
***Email (required):** _____ **Phone Number:** _____
Relationship to Patient: _____
Address same as patient
Different address: _____
Language: _____ Interpreter Required: ☐ Yes ☐ No

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PLEASE SELECT THE SERVICE YOU ARE REQUESTING FOR YOUR PATIENT

☐ **General Paediatrics**
Indicate reason:
- ☐ Medical concern
- ☐ Behavioural concern
- ☐ Learning/school difficulty
- ☐ Language delay
- ☐ Motor skills concern

(Note: we do not provide primary care or psychoeducational assessments)

☐ **Antenatal Consultation**
Provide the following information:
- Urgent? ☐ Yes ☐ No
- EDD: _____
- Antenatal records and imaging

☐ **Anxiety**
Provide list of current medications

☐ **Cardiology**
Provide the following information:
- Labs, ECG results, imaging

☐ **Dermatology**
Provide the following information:
- ☐ Acne or eczema: severity and location
- ☐ Mole: onset, features that have changed and time frame
- ☐ Hemangioma: size and location
- ☐ Rash: morphology and time frame

☐ **Endocrinology**
Provide the following information:
- Growth charts, labs, medications

☐ **Infectious Diseases**
Provide the following information:
- Labs, imaging

☐ **Neonatal Follow-Up Clinic**
(Note: this is not for routine newborn care)

☐ **Neurology**
Provide the following information:
- Medications, EEG results, imaging

☐ **Respirology/Asthma**
Provide the following information:
- ☐ Inhaled corticosteroids: _____
  - ☐ Intermittent ☐ Daily preventative
- ☐ Physician documented wheeze
- ☐ One or more courses of oral steroids
- ☐ One or more ED visits/hospitalizations for breathing issues (add details below)
- ☐ Previous PFT/chest x-ray (attach)

☐ **Rheumatology**
Provide the following information:
- Labs, medications, imaging

☐ **Registered Dietitian**
Provide the following information:
- Growth charts, labs, medications

***PLEASE SEND ALL SUPPORTING DOCUMENTS AT TIME OF REFERRAL.**
***FAILURE TO INCLUDE THE REQUISITE INFORMATION WILL RESULT IN DELAYS IN BOOKING.**

REASON FOR REFERRAL

Please provide additional information regarding the reason for referral (specify current symptoms, presenting problems, relevant history and medications).

Thank you for your referral to St Joseph's Health Centre Paediatrics. 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.

Fax completed referral form to (416) 530-6294
We will notify the patient of their appointment date and time.