ST. JOSEPH'S
UNITY HEALTH TORONTO

PEDIATRIC 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 *As per Health Card	**REFERRING PROVIDER INFORMATION**
Last Name*: _____ First Name*: _____ Middle 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 ☐ Pediatrician ☐ 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: _____ **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 Pediatrics**
Indicate reason and details below:
- ☐ 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 and details below:
- Urgent? ☐ Yes ☐ No
- EDD: _____
- Antenatal records and imaging

☐ **Anxiety**
Provide a list of current medications and details below

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

☐ **Dermatology**
Provide the following information and details below:
- ☐ Acne or eczema: severity and location
- ☐ Mole: state concern/change <u>specifically</u> and time frame for change
- ☐ Hemangioma: size and location
- ☐ Rash: morphology and time frame

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

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

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

☐ **Neonatal Continuum Clinic**

☐ **Neurology**
Provide the following information and details below:
- Medications, imaging, EEG results
  - ☐ If referring for Seizures, EEG must be ordered or will be declined.

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

***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 Pediatrics. It is also important to note that we are ***<u>not a crisis or emergency service</u>***. 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.