MICHAEL GARRON HOSPITAL
TORONTO EAST HEALTH NETWORK

# General Child & Youth Clinic Referral Form

**Tel: 416-469-6590 Fax: 416-469-6591**

*(To register, please go to the Admitting Department)*

REF

*Patient Label*

| Patient Last Name: | Given Name: | Gender: | Date of Birth: (Day / Month / Year) |
|---|---|---|---|
| Address: | | Apt#: | Telephone Number - Home: |
| Town or City: | Province: | Postal Code: | Parent/Guardian's Telephone - Cellular: |
| Parent / Caregiver / Guardian: | | Relationship To Patient: | Parent/Guardian's Telephone - Work: |
| Family Physician / Paediatrician: | | | Other Parent/Guardian's Tel. - Cellular: |
| **Ontario Health Card Number:** Version Code | **Email Address For Virtual Consult (Telephone/Video):** | | Other Parent/Guardian's Tel. - Work: |

**Required Questions:**

**INTERPRETER** - Language interpreter required? ☐No ☐Yes - If YES, language:
- American Sign Language interpreter required? ☐No ☐Yes

**PRIVACY** - May we call the patient or leave a message? ☐No ☐Yes
If NO, who can we contact? Name: Tel:

**Clinical Information:**

**Reason For Referral:**

**Medications:**

**History / Current Issues:**

**Relevant Past History / Family History:**

**MGH ER Follow-up:**

*Urgent:*
☐ 48-72 hr (direct-booking from ER)

*Semi-urgent:*
☐ 1-2 week (to be booked by paediatrician ONLY)

*Non-urgent:*
☐ Gen paeds (to be booked by paediatrician ONLY)

**IMPORTANT**
**PLEASE READ:**

**INCOMPLETE REFERRALS WILL BE RETURNED FOR COMPLETION**

**PLEASE SEND:**

- **ALL PERTINENT DIAGNOSTIC & LAB RESULTS**
- **LIST OF CURRENT MEDICATIONS**
- **CONSULTNOTES / DISCHARGE SUMMARY**
- **INVESTIGATIONS**
- **GROWTH CHART**

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☐ Gen Paeds Consulting
☐ Newborn Assessment
☐ Development Assessment
- ○ Regional Neonatal Follow UP Clinic (0-36 months)
- ○ General Paeds Consulting Clinic (all ages)

☐ Tongue Tie Release
☐ Healthy Lifestyle Clinic (Obesity Management)
☐ Neurology Clinic
☐ Infectious Disease
☐ Adolescent Medicine
☐ Paeds/Adolescent Gyne
☐ Cardiology
☐ Respirology (Asthma)
☐ Endocrinology(does not include Diabetes-refer to local Paediatric Diabetes Education Program)
☐ Nutrition Clinic
☐Gastroenterology/Hepatology

| **Referring Physician:** | Physician Name: | Telephone Number: | Fax Number: |
|---|---|---|---|
| | Physician's Signature: | Billing#: | Date: |

**Appointment:**