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Referral Form

Patient Information (Affix patient label)

Patient Name: _____ Gender: _____
 OHIP Number: _____ Email address(required): _____
 Date of Birth (dd/mm/yy): _____ "Guardian 1" name: _____
 Phone Number: _____ "Guardian 2" name: _____
 Address: _____

Referral to:

General Pediatrics

Speciality Clinic:

- Infant Feeding Clinic: MD, OT, RD
- Breastfeeding Medicine: MD, LC
- Travel Medicine- Dr. Posen, Joshua
- Developmental Pediatrics: Dr. Nguyen, Claire
- Behavioural and Mental Health Pediatrics: Dr. Singer, Arielle
- Pediatric Dermatology Clinic: Dr. Sibbald, Cathryn
- Pediatric Clinical Allergy and Immunology: Dr. Sud, Shama
- Pediatric Nephrology OR Bowel/Bladder Dysfunction: Dr. Betcherman, Laura
- Infectious Diseases: Dr. Posen, Joshua
- Pediatrician and Adolescent Medicine: Dr. McSheffrey, Gordon

Allied Health Services:

- Dietitian
- Lactation Consultant
- Occupational Therapy
- Speech Language Pathology
- Social worker / Psychotherapy

Reason for Referral:

Urgent

Not Urgent

Referring Physician:

Physician Name

Billing Number

Address

Tel

Fax

Physician Signature:

Date: