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Web: bloorkids.com
Phone: {647) 483-1502
Fax: (647) 480-0909

Referral Form

Patient Information **(Affix patient label)**

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

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 (on Mat leave)
☐ Pediatric Dermatology Clinic: Dr. Sibbald, Cathryn
☐ Pediatric Clinical Allergy and Immunology: Dr. Sud, Shama; Dr. Duan, Lucy
☐ Pediatric Nephrology OR Bowel/Bladder Dysfunction: Dr. Betcherman, Laura
☐ Infectious Diseases: Dr. Posen, Joshua
☐ Pediatrician and Adolescent Medicine: Dr. McSheffrey, Gordon
☐ Pediatric Cardiology: Dr. Wong, Jonathan P

Allied Health Services:

☐ Dietitian
☐ Lactation Consultant
☐ Occupational Therapy
☐ Speech Language Pathology (temporarily closed)
☐ Social worker/ Psychotherapy

Reason for Referral: ☐ Urgent ☐ Not Urgent

Referring Physician:

Physician Name Billing Number

Address

Tel Fax

Physician Signature: Date: