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Toronto, Ontario M5G 1X8
Phone: 416-813-1500
www.sickkids.ca
fax: see list

Please use our online referral form for your next request for consultation

Ambulatory Clinic/Service Referral Form

* indicates required information

*Please indicate clinic/service:_____

*Reason for referral (e.g. diagnosis, symptoms, test or procedure)_____

Medical information

Please provide a brief history, any relevant or recent investigations, current medications and physical findings. This information should include all aspects of care. If requesting a second opinion, please indicate reason. Please contact the specific clinic/service area for guidelines/criteria, or view our website.

_____
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Urgent: Yes □ No □

Indicating the urgency will prompt the SickKids professional to ensure that the referral is reviewed in a timely manner. Referrals will be triaged and scheduled based on a standard priority ranking scale for the particular problem. The referring professional and/or patient (family) will be notified by the SickKids clinic/service area of the booking or suggested alternate plan.

Do you have accompanying information? Yes □ No □

Please send all supporting documents, test/results or investigations with this referral.

Patient Information

*First Name:_____ *Last_____

*Date of birth:_____ *Sex: Male □ Female □

*Home address:_____ *Telephone:_____

_____ Alternate phone #: _____

*Will an interpreter be required? Yes □ No □ Language: _____

Previous SickKids patient? Yes □ No □

If yes, please provide:

Clinic and doctor name: _____

Medical Record Number (history number): _____

Health Card number: _____ Health Card version (*if applicable*):_____

Health Card province:_____ Health Card expiry date:_____

Parent/guardian information

Mother's name:_____ Father's name:_____

Mother's phone #:_____ Father's phone#:_____

Mother's address if different from patient: Father's address if different from patient:

_____

_____

_____

Note: Please indicate custodial parent, if applicable: Mother_____ Father_____

Guardian's name:_____ Guardian's phone #:_____

Alternate phone #:_____

Referring professional information

*First name: _____ *Last name: _____

*Professional designation :_____(*please specify e.g. paediatrician, GP, PHN etc.*)

*Billing number *(if applicable)*:_____

*Mailing address:_____

_____

*Telephone:_____ *Fax:_____

E-mail address:_____ Is a Telehealth site available to you: Yes □No □

Online Referral :

http://www.sickkids.ca/AmbulatoryClinics/index.html