# Kids Care Consultation Referral Form

**Centenary Site - Paediatric Inpatient Unit 7th floor - Phone: 416-281-7013, Fax: 416-281-7102**

**General Site – Crockford Wing, 1st Floor – Phone: 416-438-2911x3415, Fax: 416-431-8249**

**Birchmount Site – Main Floor, near Emergency Dept. – Phone: 416-495-2886, Fax: 416-495-2538**

<table>
<thead>
<tr>
<th>HIGH PRIORITY within 1-3 days</th>
<th>ROUTINE in 1-2 weeks</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Patient’s last name: ______________________</th>
<th>First name: ______________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>OHIP no.: ______________________</td>
<td>Version code: ______________________</td>
</tr>
<tr>
<td>Address: ______________________</td>
<td></td>
</tr>
<tr>
<td>City: ______________________</td>
<td>Postal code: ______________________</td>
</tr>
<tr>
<td>Phone #: ______________________</td>
<td>Parent’s cell phone #: ______________________</td>
</tr>
</tbody>
</table>

## Reason for referral:

- Febrile seizures
- Prolonged fever
- Rash
- Persistent cough
- New onset headaches
- Abdominal pain
- Syncope
- Recurrent UTI
- Lymphadenopathy
- MSK pain
- Limping without fever
- Recurrent chest pain
- Newborn condition
- Other

Details: __________________________________________ |
| __________________________________________________ |
| __________________________________________________ |

**Did the patient have recent investigations:** NO YES (please fax results)

**Did the patient receive recent medications:** NO YES: ______________________ |

**Underlying conditions:** None YES: ______________________ |

Referring MD: ______________________ Billing no.: ______________________ Date: ________________

Family MD (if different from referring physician): ______________________ |

Appointment Booked: Date: ______________________ Time: ______________________