Scarborough Health Network – Centenary Site
2867 Ellesmere Road, 12th Level,
Scarborough, ON. M1E 4B9
Phone: 416-281-7476

Galaxy 12
Bank of Montreal Child and Teen Clinics

REFERRAL FORM

Please ensure all Information is legible & complete to facilitate a prompt appointment

For Clinics Below fax to 416-281-7313:

- ☐ Gastroenterology Clinic:☐ Dr. Durno ☐ Dr. Yeung
- ☐ Regional Neonatal F/U Clinic
- ☐ Sickle Cell Clinic
- ☐ Nephrology Clinic
- ☐ Adolescent Child & Teen Clinic
- ☐ RSV Prophylaxis Clinic
- ☐ Haematology Clinic
- ☐ Rheumatology Clinic:☐ Dr. Danayan ☐ Dr. Rachlis
- ☐ Neurology Clinic
- ☐ Bladder/Bowel Dysfunction Clinic
- ☐ Diabetes Clinic:☐ Dr. Basak ☐ Dr. Gan-Gaisano
- ☐ Scoliosis Clinic

For Clinics Below fax to 416-284-3168:

- ☐ HOPPS Clinic

For Clinics Below fax to 416-281-7102:

- ☐ Allergy Clinic:☐ Dr. Segal ☐ Dr. Ching
- ☐ Dermatology
- ☐ Paediatric Consult

For Clinics Below fax to 416-281-7307:

- ☐ Nutrition Counseling Centre

NON-URGENT: ☐ **URGENT: ☐**

Patient Name _____

DOB _____Male_____ Female _____

Address_____City_____Postal Code _____

Home Phone # (_____)_____ Can patient be called at this number ___Y _____N

Alternate Phone # (_____)_____ Language Spoken_____

Health Card # _____Version Code _____

Name of Parent/Guardian/Contact Person _____Phone#(_____)_____

Contact Email Address ***(please sign attached consent from)***_____

Reason for Referral _____

_____

Family Doctor_____ Physician # _____

Phone # _____Fax#_____

Address_____City_____Postal Code _____

Referring Doctor_____ Physician # _____
(If not the same as family physician)

Phone # _____Fax#_____

Address_____City_____Postal Code _____

Please fax your completed referral form to the appropriate clinic (listed above) along with any RECENT Diagnostic & Laboratory Investigations.
Please only fax ONE copy of the referral per patient.

Revised Feb 24, 2020: FORM# 368

For internal use only:

_____
Appointment Date and Time