Kids Care Consultation Referral Form

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

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

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

☐ **HIGH PRIORITY** within 1-3 days ☐ **ROUTINE** in 1-2 weeks

Patient's last name: _____ First name: _____

☐ Male ☐ Female DOB (d/m/y): _____

OHIP no.: _____ Version code: _____

Address: _____

City: _____ Postal code: _____

Phone #: _____ Parent's cell phone #: _____

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: _____