Humber River Health
Lighting New Ways in Healthcare™

Maternal & Child Program

PAEDIATRIC OUTPATIENT CLINICS REFERRAL FORM

1235 Wilson Ave, 4th Floor, Toronto, ON M3M 0B2 P: 416-242-1000 (x21400) F: 416-242-1095

PLEASE FAX FORM TO (416) 242-1095

Patient Information:		
Name:		DOB:
Address:	City:	Postal Code:
OHIP #:		Version Code:
Parents Full Names/Guardian's Name:		
Home Phone Number:	Work Phone Number:	
Email Address:		
Referring Physician's Name:	Phone Number:	

☐ **Asthma** ☐ **Allergy** ☐ **Cardiology**

☐ **Endocrinology** ☐ **Gastroenterology** ☐ **Neonatal Follow-Up**

☐ **Orthopaedic** ☐ **RSV** ☐ **General Surgery**

☐ **Neurology**

Reason For Referral	
Physician Signature:	Date: