***NOTE: Incomplete and / or unsigned requistions will be returned***

# Paediatric Outpatient Clinic Referral

Markham Stouffville Hospital Booking Line: **905-472-7534**

Please Fax To: **905-472-7535**

- ☐ **Assessment Clinic**
- ☐ **Newborn Clinic**
- ☐ **Endocrinology Clinic**
- ☐ **Elimination Clinic**

☐ Urgent (1-2 days) ☐ Non Urgent (within 1 week)

Preferred date: ___________________________

PLEASE PRINT CLEARLY
OR AFFIX LABEL WITH COMPLETE INFORMATION

Patient Name: ______________________ (Last) (First)

Date of Birth: ______________________ (Day) (Month) (Year) Sex: F M

Health Card # ______________ Version Code: __________

☐ WSIB # ______________ ☐ Non OHIP (Self-pay) or Refugee

Address: ______________________ Postal Code: __________

Telephone # (Best Daytime): ______________________

Alternate #: ______________________

Family Physician: ______________________

| **Date** | **Referring MD** | | **Signature** |
|---|---|---|---|
| **CPSO #** | **Billing #** | **Telephone** | **Fax** |
| **Address** | | **City** | **Postal Code** |
| Additional Reports to: | | | |
| **Parent/Guardian/Contact** | | **Phone #** | |
| Preferred Language | Name & number of interpreter to help schedule appointment, if available<br>**Please bring interpreter to the appointment if required.** | | |
| **Date of Birth** | **Time of Birth** | **Gestational Age at Birth** | **Birthweight** |
| **Past Medical History/Reason for Referral** | ☐ Newly Diagnosed | | |
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**For Paediatric Assessment Clinic Referral, please attach all relevant lab testing, diagnostic imaging and growth charts, as applicable.**

**For Paediatric Endocrinology Clinic, please attach any pertinent lab reports.**

**This referral will be processed more efficiently if pertinent medical reports are sent with the referral.**

**Incomplete or illegbile referrals will be returned to your office.**