



REFERRAL FORM

Patient Information (Affix Label)

Last Name:
First Name:
Date of Birth:
OHIP#:
Phone: H: VC: C:

Referral to:

GENERAL PEDIATRICS

- General Pediatrics Consultants

PEDIATRIC SPECIALISTS

- Allergy/Immun, Endocrinology, Hematology/Oncology, Gastroenterology, Adolescent Sexual Health, Infectious Disease, Lactation Medicine, Nephrology, Dermatology, Rheumatology, Urology, Circumcision

MULTIDISCIPLINARY TEAMS

- Bladder and Bowel Dysfunction Clinic, Wart/Eczema/Acne/Molluscum Clinic, Obesity, Medical Nutrition, and Healthy Living Program, Breastfeeding and Tongue Tie Release Clinic, Autism and Social Communication Assessment Clinic

PSYCHOLOGY AND ALLIED HEALTH SERVICES

- Child Psychology Services, Lactation Consultation Services (in clinic), Physiotherapy, Occupational Therapy, Dietitians, Speech Language Therapy

Reason for Referral:

Referring MD: MD Billing #:
MD Address: Phone: Fax:
Signature: Today's Date:

Fax Referrals to 416-848-7664

Forest Hill: Suite 301 - 491 Eglinton Ave W, Toronto, ON M5N 1A8
Leaside: Suite 201 - 25 Industrial Street, Toronto, ON M4 G1Z2
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