



Maternal & Child Program

OUTPATIENT PAEDIATRIC FOLLOW-UP CLINIC REFERRAL FORM

Please FAX this referral form to 416-242-1095 with a copy of the PATIENT'S EMERGENCY RECORD SHEET

- Asthma
- Allergy
- RSV
- Neurology
- Cardiology
- Paediatric Follow-Up

Referring Physician: _____ Date: _____
(print name)

Reason for Referral:

Referring Physician Signature

Date

Patient Appointment Date: _____ Time: _____

OUTPATIENT PAEDIATRIC FOLLOW-UP CLINIC
Humber River Hospital
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 Toronto, ON M3M 0B2
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