



Patient Information

**PAEDIATRIC OUTPATIENT CLINICS  
REFERRAL FORM**

**Please FAX this referral form to (416) 242-1095**

- Asthma
- Allergy
- Cardiology
- Endocrinology
- Gastroenterology
- Neonatal Follow-up
- Orthopaedic
- RSV
- General Surgery
- Neurology

Reason for Referral: \_\_\_\_\_  
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\_\_\_\_\_  
Referring Physician (Print Name)

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date