

Paediatric Referral Form

Patient Name: _____ Referring Physician: _____
 Parent/ Guardian Name: _____ PRAC ID: _____
 Relation to patient: _____ Phone: _____ Fax: _____
 Phone: _____ Fax: _____ Address: _____
 Date of Birth (DOB): _____ PHN: _____ Family Physician (If different): _____
 Phone: _____ Address: _____
 Address: _____ Phone: _____ Fax: _____

Please return completed referral form to either :

Fax : 587 557 4466 or 587 635 6211

Purpose of referral :

- Routine Paediatric care**
- ADHD Assessment**
- Medical issue (write reason below)**

Clinical Information / Reason for Consultation:

*Please attach Growth Chart (Recent Height, Weight, Head Circumference)

* Please attach current list of medications and allergies.

Referring Physician Signature: _____ **Date:** _____

Preferred Contact for Booking (if applicable): _____