

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

PLEASE PRINT CLEARLY  
OR AFFIX LABEL WITH COMPLETE INFORMATION

MARKHAM STOUFFVILLE HOSPITAL CORPORATION

**PAEDIATRIC OUTPATIENT CLINIC REFERRAL**

Markham Site Booking Line: **(905) 472-7534**

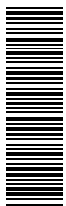
Please Fax To: **(905) 472-7535**

- Ambulatory Clinic       Diabetes Clinic
- Newborn Clinic         Endocrinology Clinic
- Urgent (1-2 days)     Non Urgent (within 1 week)

Preferred date: \_\_\_\_\_

Patient Name: _____	
Last	First
Date of Birth: _____	Sex: F M
Day                      Month                      Year	
Health Card # _____	Version Code: _____
Address: _____ Postal Code: _____	
Telephone # (Best Daytime): _____	
Alternate #: _____	
Family Physician: _____	

<b>Date</b>	<b>Referring MD</b>	<b>Signature</b>	
<b>Billing #</b>	<b>Telephone</b>	<b>Fax</b>	
<b>Address</b>		<b>City</b>	<b>Postal Code</b>
Additional Reports to:			
<b>Parent/Guardian/Contact</b>		<b>Phone #</b>	
Spoken Language if other than English. <b>Please bring translator to the appointment if required.</b>			
<b>Date of Birth</b>	<b>Time of Birth</b>	<b>Gestational Age at Birth</b>	<b>Birthweight</b>
<b>Past Medical History/Reason for Referral</b>		<input type="checkbox"/> Newly Diagnosed	



**For Paediatric Ambulatory Clinic Referral, please attach all relevant lab testing, diagnostic imaging and growth charts, as applicable.**

**For Paediatric Diabetes/Endocrine 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 illegible referrals will be returned to your office.**