NOTE: Incomplete and / or unsigned requistions 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**

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

☐ **Ambulatory Clinic** ☐ **Diabetes Clinic**
☐ **Newborn Clinic** ☐ **Endorinology Clinic**
☐ Urgent (1-2 days) ☐ Non Urgent (within 1 week)
Preferred date: _____

Date	**Referring MD**	**Signature**
Billing #	**Telephone**	**Fax**
Address	**City**	**Postal Code**
Additional Reports to:		
Parent/Guardian/Contact	**Phone #**	
Spoken Languange if other than English. **Please bring translator to the appointment if required.**		

Date of Birth	**Time of Birth**	**Gestational Age at Birth**	**Birthweight**

Past Medical History/Reason for Referral ☐ 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 illegbile referrals will be returned to your office.