William Osler Health System

Peel Memorial Centre for Integrated Health and Wellness
20 Lynch St, Brampton, ON L6W 2Z8
Phone: 905-863-2552
Fax: 905-863-2468

Patient Identification

Paediatric Consultation

REFERRAL FORM

Service Information

Referral Source ☐ Emergency Department/ UCC ☐ Acute Care ☐ Primary Health Care ☐ Other _____

Please see over for service specific referral information

- ☐ Chest Clinic
- ☐ Endocrinology Clinic (☐ PMC ☐ EGH)
- ☐ GI Clinic (☐ PMC ☐ EGH)
- ☐ Healthy Lifestyle Clinic
- ☐ Nephrology Clinic
- ☐ Neurology Clinic (☐ PMC ☐ EGH)
- ☐ Occupational Therapy Paediatric Outpatient Referral
- ☐ Paediatric and Obstetric Clinical Nutrition Services
- ☐ Sickle Cell Clinic
- ☐ UCC Paediatric Consult Service *(Leave in UCC consult room, do not fax)*

Patient Information

Patient's Last Name: _____ **Patient's First Name:** _____

Date of Birth: (DD/MM/YY) _____ **Gender:** ☐ Male ☐ Female ☐ Other

Health Card Number: _____ **Version:** _____ **No OHIP:** ☐

Address: _____ **City:** _____ **Province:** _____ **Postal Code:** _____

Phone # (primary): _____ **Phone # (alternate):** _____ **Cell #:** _____

Patient's E-mail: _____ ☐ **Interpretation Services Required; Language:** _____

Person to contact for booking appointment *(If different than patient):* _____

Relationship to patient: _____

Reason for Referral & Relevant Patient History

Reason for Referral: _____

Relevant History: _____

Allergies: _____

Investigations to Date: _____

Current Medications: _____

Referring Clinician Information

Referring Clinician Name: _____ **OHIP Billing Number:** _____

Phone #: _____ **Fax #:** _____ **E-mail:** _____

Family Physician *(If different from above)*: _____

Signature of Referring Clinician: _____ **Referral Date:** _____

Clinic Use Only

Date Referral Screened: _____
Date Appt. Booked: _____
Date of Appt.: _____

Referral Received Actions:

- ☐ Approved
- ☐ Patient Declined
- ☐ Redirected to _____
- ☐ Other _____

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Please Complete Sections Below for Relevant Clinic Referrals

Healthy Lifestyle Clinic (5-18 years of age only)

Diagnosis/ Reason for Referral

- ☐ Obesity (BMI or wt for ht > 85th percentile)
- ☐ Hyperlipidemia
- ☐ Other risks: _____
- ☐ Other Comments: _____

Current Weight: _____ Height: _____ BMI: _____

PLEASE ATTACH LABORATORY DATA AND GROWTH DATA
(GROWTH CHARTS, WEIGHT AND HEIGHT HISTORY ARE MANDATORY FOR PAEDIATRIC REFERRAL)

Occupational Therapy Paediatric Outpatient Referral

☐ Feeding
- ☐ Sensitivity to texture
- ☐ Refusal to eat
- ☐ Oral-Motor Dysfunction
- ☐ Swallowing Dysfunction
- ☐ Nutritionally Compromised

☐ Developmental Delay
- ☐ Gross Motor
- ☐ Fine Motor
- ☐ Cognitive
- ☐ Psychosocial issues

☐ Musculoskeletal
- ☐ Orthopaedic
- ☐ Soft tissue
- ☐ Plagiocephaly
- ☐ Positioning deficit

Relevant History and Treatment to Date: _____

OT Treatment Requested: _____

Paediatric and Obstetric Clinical Nutrition Services

GROWTH INFORMATION

- ☐ Growth chart/history is mandatory for **ALL** paediatric referrals
- ☐ Growth charts developed by the World Health Organization and adapted for Canada are recommended to track growth for all infants, children and teens; they can be found at **www.whogrowthcharts.ca**

LABORATORY DATA

- ☐ Please attach relevant laboratory data

Paediatrics:

- ☐ Obesity (Weight-for-Length or BMI >85th %ile) and/or Hyperlipidemia
  - EGH: all children
  - PMC: <5years of age; if ≥5 years please refer to Lifestyle Clinic
- ☐ Failure to Thrive (Weight-for-Length or BMI <3rd %ile)
- ☐ Altered Growth Velocity
- ☐ Significant Iron Deficiency Anemia (Hgb <90)
- ☐ Tube Feeding Assessment/Monitoring
- ☐ Food Allergies (specify: _____)
- ☐ Complex Feeding Issues (e.g. inappropriate texture of diet, developmental delay affecting intake, GERD) (specify: _____)

Obstetrics:

- ☐ Hyperemesis Gravidarum
- ☐ Adolescent Pregnancy (<18 years old)
- ☐ Poor Weight Gain
- ☐ Hypertension
- ☐ Obesity (pre-pregnancy BMI ≥30) **NOTE**: If BMI ≥40, please refer to Special Pregnancy Program at Mount Sinai Hospital (they will accept referrals if BMI <40 + complications/medical issues)

Clinic Use Only

Date Referral Screened: _____
Date Appt. Booked: _____
Date of Appt.: _____

Referral Received Actions:
- ☐ Approved
- ☐ Patient Declined
- ☐ Redirected to _____
- ☐ Other _____

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