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Toronto, Ontario  
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Telephone: 416-813-1500  
Fax: [see list](#)  
Web Site: [www.sickkids.ca](http://www.sickkids.ca)

\*\*\*Please use our online referral form for your next request for consultation\*\*\*

## Ambulatory Clinic/Service Referral Form

\* indicates required information

\*Please indicate **Clinic/Service**: \_\_\_\_\_

\*Please indicate "**problem**" (e.g. diagnosis, symptoms, test or procedure) \_\_\_\_\_

**Note:** See guidelines/criteria for the specialty problem you are referring to. Contact the specific clinic for details on guidelines/criteria

### Referring Professional Information

\*First Name: \_\_\_\_\_

\*Last Name: \_\_\_\_\_

\*Professional Designation : \_\_\_\_\_ ( please specify e.g. pediatrician, GP, PHN etc.)

\*Billing Number (if applicable): \_\_\_\_\_

Institution/Agency: \_\_\_\_\_

\*Mailing Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\*Telephone: \_\_\_\_\_

\*Fax: \_\_\_\_\_

e-mail address: \_\_\_\_\_

Is a Telehealth site available to you: Yes  No

### Patient Information

\*First Name: \_\_\_\_\_

\*Last Name: \_\_\_\_\_

\*Date of Birth: \_\_\_\_\_

\*Sex: Male  Female

\*Home Address: \_\_\_\_\_

\*Telephone: \_\_\_\_\_

Alternate phone #: \_\_\_\_\_

\*Language: \_\_\_\_\_

\*Will an interpreter be required? Yes  No

SickKids Medical Record Number (history number): \_\_\_\_\_

Ambulatory Referral Form

Health Card Number: \_\_\_\_\_ Health Card Version (if applicable): \_\_\_\_\_

Health Card Province: \_\_\_\_\_ Health Card Expiry Date: \_\_\_\_\_

**Parent/Guardian Information**

Mother's Name: \_\_\_\_\_ and/or Father's Name: \_\_\_\_\_

Mother's alternate phone # \_\_\_\_\_ Father's alternate phone# \_\_\_\_\_

Mother's address # if different from patient: \_\_\_\_\_ Father's address if different from patient: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Note: Please indicate custodial parent, if applicable: Mother \_\_\_\_\_ Father \_\_\_\_\_

Guardian's Name: \_\_\_\_\_ Guardian's Phone number: \_\_\_\_\_

Alternate phone #: \_\_\_\_\_

**Note: The following information included on the next page is helpful when triaging this referral, failure to provide appropriate or complete information may lead to patient not being seen in a timely manner**

**Medical Information and Reason for Referral**

**Please provide a brief history, any relevant or recent investigations, current medications and physical findings. This information should include all aspects of care. If requesting a second opinion, please indicate reason.**

Please contact the specific clinic/service area for guidelines/criteria or view our Web site.

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Urgent: Yes  No

Indicating the urgency will prompt the SickKids professional to ensure that the referral is reviewed in a timely manner. Referrals will be triaged and scheduled based on a standard priority ranking scale for the particular problem.

The referring professional and/ or patient (family) will be notified by the SickKids clinic/service area of the booking or suggested alternate plan.

## Ambulatory Referral Form

**Do You Have Accompanying Information?** Yes  No

**Note: Please include the specific clinic/service requested in the mailing address.  
Please send all supporting documents, test/results or investigations with this referral.**

**Disclaimer:**

**Please note:** Referrals may be redirected to other partnering healthcare providers by hospital personnel. Please discuss this possibility with your patients/ and their families prior to submitting a referral to the hospital.

Please note while patients are awaiting elective consultation, The Hospital for Sick Children cannot accept responsibility for their care, until the patient has actually been seen. As their referring physician, you remain responsible for their care until seen at The Hospital for Sick Children.