NOTE: Incomplete and / or unsigned requistions will be returned

Markham Stouffville Hospital
Oak Valley Health

Paediatric Outpatient Clinic Referral

Markham Stouffville Hospital Booking Line: **905-472-7534**
Please Fax To: **905-472-7535**

☐ **Ambulatory Clinic** ☐ **Endocrinology Clinic**
☐ **Newborn Clinic** ☐ **Elimination Clinic**

☐ Urgent (1-2 days) ☐ Non Urgent (within 1 week)
Preferred date: _____

PLEASE PRINT CLEARLY
OR AFFIX LABEL WITH COMPLETE INFORMATION

Patient Name: _____ (Last) _____ (First)
Date of Birth: _____ (Day) _____ (Month) _____ (Year) Sex: F M
Health Card # _____ Version Code: _____
☐ WSIB # _____ ☐ Non OHIP (Self-pay) or Refugee
Address: _____ Postal Code: _____
Telephone # (Best Daytime): _____
Alternate #: _____
Family Physician: _____

Date	**Referring MD**	**Signature**	
CPSO #	**Billing #**	**Telephone**	**Fax**
Address		**City**	**Postal Code**
Additional Reports to:			
Parent/Guardian/Contact		**Phone #**	
Preferred Language	Name & number of interpreter to help schedule appointment, if available **Please bring interpreter 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 Endocrinology 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.