Markham Stouffville Hospital
Oak Valley Health

Paediatric Assessment Clinic Physician Referral

Phone: 905-472-7534 Fax: 905-472-7535

To	
Specialty	
Referral Date	**Fax**

Patient Name:	Date of Birth:
Address:	Health Card #
Parents *Last* *First* Mother's Name:	Home Phone
	Work Phone
Father's Name:	Home Phone
	Work Phone

Appointment Date: *(DD/MM/YY)* _____

Reason for Referral

Other Significant Medical History

Medication

Referring Physician **Physician phone:**	**Signature**	**Physician for follow-up**