Kingston Health Sciences Centre
Centre des sciences de la santé de Kingston

NEW PATIENT REFERRAL FAX FORM
Fax this Referral to KHSC – Pediatrics
@ 1-855-228-9737

*For **assistance** completing contact **KHSC - Pediatrics** @ (613) 549-6666 ext. 6375.*

PATIENT INFORMATION			
Surname		Mobile	
First name		Home	
Date of Birth (yyyy/mm/dd)		Business + Ext	
Street Address			
City, Province, Postal Code			
Health Card Number, Version Code, Province			
Email			

CLINICAL INDICATION / HISTORY	
Urgency	.

Please Note: Patients who require same day or very urgent referral should be discussed with the Pediatrician on call 24/7 or in the Children's Outpatient Centre (Monday-Friday 9am-4pm)

Patient has a sibling that has been seen or followed by a Pediatrician before	.
	If ***yes,*** provide details and *attach relevant information* as outlined at bottom of form.
	Name of Sibling(s)
	Name of Pediatrician

SUB-SPECIALTY		
Select Sub-Specialty	☐	General Consulting Pediatrics
	☐	Pediatric Hematology / Oncology
	☐	Pediatric Respirology / Cystic Fibrosis
	☐	Pediatric Asthma
	☐	Pediatric Diabetes
	☐	Pediatric Endocrinology
	☐	Pediatric Cardiology
	☐	Pediatric Infectious Disease
	☐	Pediatric Neurology / Epilepsy
	☐	Neonatology / Prenatal Consultation / Neonatal Follow-up
	☐	Pediatric Gastroenterology
	☐	Other

REASON FOR REFERRAL	
What would you like addressed by this referral?	

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ADDITIONAL PATIENT INFORMATION					
Patient / Guardian is aware of the referral	.				
Patient's Parent / Guardian Name					
Patient's Parent / Guardian Email (if different from above)					
Patient requires a translator	.	If ***Yes***, indicate Language			
Height (cm)		Weight (kg)		Gender	.

CURRENT or PAST DIAGNOSES	
Current Problems	
Past Medical History (e.g. birth history)	

CURRENT MEDICATIONS / TREATMENTS	
Medications	
Treatments	

ADDITIONAL RELEVANT INFORMATION	
Details	

Please **attach** relevant information, including:

- Cumulative patient profile (CPP)
- Growth chart
- Imaging reports
- Immunization records
- Investigation results
- Lab reports

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REFERRING CLINICIAN INFORMATION	
Include the following information in the space provided to the right: (can use a label or stamp) Site Name Phone Fax Address City, Province, Postal Code Billing Number Professional ID Clinician Type	
Signature	
Printed Name, Designation	
Date (yyyy/mm/dd), Time (hhmm)	
Copy of referral and / or status updates to be sent to:	