Pediatric and Adolescent Medicine

Thrive KIDS CLINIC
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PATIENT INFORMATION (affix label here)

Child's Last Name: _____ Child's First Name: _____
DOB (MM/DD/YYYY): _____ Gender: _____ Ph #: _____
OHIP #: _____ VC: _____
Address: _____
Email Parent 1: _____ Email Parent 2: _____

SELECT THE SERVICE YOU ARE REQUESTING

General Paediatrics Consults
[ ] Medical Concern
[ ] Behavioural Concern
[ ] Developmental / Learning / School Difficulty
[ ] Language Delay
[ ] Motor Skills Concern

Specialty Clinic
[ ] ADHD Evaluation
[ ] Adolescent Medicine (Teenage Health)
[ ] Gender Affirming Care
[ ] Anxiety / Depression
[ ] Acne
[ ] Sleep Concern (Pediatrican, certified sleep consultant)
[ ] Breastfeeding Concern, seen with lactation consultant (1st visit covered by OHIP)

Pediatric Allied Health
[ ] Virtual Dietitian
[ ] Virtual Social Worker / Psychotherapy
[ ] Lactation Consultant / Breastfeeding

[ ] **Newborn Care**
[ ] Failure to Thrive
[ ] Plagiocephaly
[ ] Delivery Complications
[ ] Neo-natal conditions
[ ] Symptomatic GERD
[ ] Reflux

[ ] **URGENT** [ ] **NOT URGENT**

Note: Our practice does not accept Autism-related services or psychoeducational testing. Referrals mentioning these will be declined and returned to ensure the patient is waitlisted at an appropriate facility. We may offer virtual consults based on service requested.
Language: We offer services in English and Spanish only. Translation services are not provided. If needed, please bring someone who can interpret.

REASON FOR REFERRAL (symptoms, presenting problems, relevant history, medications)

If patient is over 12 months for ongoing care, please include all relevant medical records.

REFERRING PROVIDER *Rejected without MD Billing #

MD Name: _____ MD Billing #: _____
Ph #: _____ Fax #: _____
MD Signature: _____ Today's Date: _____