Physician Referral Form

2686 Danforth Avenue,
Toronto, Ontario M4C 1L7
T: (416) 849-2260
F: (416) 849-2261
info@thrivekidsclinic.ca
www.thrivekidsclinic.ca

PATIENT INFORMATION (AFFIX LABEL IF AVAILABLE)

Childs Last Name:
Childs First Name:
DOB (MM/DD/YYYY) **Gender:**
OHIP # **VC:**
Ph#
Email Parent 1:
Email Parent 2:

PLEASE SELECT THE SERVICE YOU ARE REQUESTING FOR YOUR PATIENT

□ **General Paediatrics Consults**
□ Medical Concern
□ Behavioural concern
□ Developmental/Learning/school difficulty
□ Language delay
□ Motor Skills Concern

□ **Pediatric Allied Health Services**
□ Virtual Dietitian
□ Virtual Social worker / Psychotherapy
□ Lactation Consultant / Breast feeding

Specialty Clinic:
□ ADHD Evaluation
□ Gender Affirming Care
□ Newborn Circumcisions (under 2 months only)
□ Breastfeeding Concern, seen with lactation consultant (1st visit covered by OHIP)

○ Urgent ○ Not Urgent

We do not provide psychoeducational assessments, mental health (anxiety, depression) or autism evaluation. Referral is for evaluation only.

REASON FOR REFERRAL

Please provide additional information regarding the reason for referral (specify current symptoms, presenting problems, relevant history and medications).

Referring MD:_____ **MD Billing # _____*rejected without**
MD Address: _____
Ph#: _____FAX #_____

MD Signature: _____
Todays Date:_____

Fax referrals to (416) 849-2261, response in 2-3 business days .

Located at Main Street and Danforth Ave. across from the Canadian Tire. Space is limited be mindful of bringing strollers in the clinic