Trillium Health Partners
Better Together

Last Name: _____ First Name: _____

Date of Birth (DD/MM/YYYY): _____/_____/_____

Health card #: _____

MRN #: _____

CSN #: _____

THP use only

Affix patient encounter label here/complete all fields if label not available.

THP PAEDIATRIC GENERAL MEDICINE CLINIC REFERRAL

Trillium Health Partners – Family Care Centre
77 Queensway West, Suite 201, Mississauga, ON, L5B 1B7
P – 905-848-7653 F – 905-804-7741

Please fax referral form and any supporting documentation required to process the referral

Reason for Referral

Medical Referrals that the clinic will support include but are not limited to:

- ☐ Respiratory: asthma
- ☐ Gastrointestinal: constipation, reflux/ GERD or cow's milk protein allergy
- ☐ Neurological: headaches or first seizure
- ☐ Cardiovascular: murmur
- ☐ Musculoskeletal: joint pain/ swelling
- ☐ Other: failure to thrive, jaundice beyond 1 month of age, abnormal blood work results, anemia, etc

Exclusion Criteria

- Developmental Delay, Autism
- Behavior Disorders
- Mental Health Disorders
- Eating Disorders
- School Difficulties
- Primary Care
- Children who have a paediatrician (unless for a second opinion)
- Children residing outside of Mississauga/South Etobicoke

***This clinic cannot accommodate urgent referrals. We aim to see patients within 8 weeks.**

PATIENT DEMOGRAPHICS:

Last Name: _____ First Name: _____ Date of Birth (DD/MM/YYYY): _____/_____/_____

Health Card #/VC: _____ Legal Sex: ☐ Female ☐ Male ☐ Non-Binary ☐ Unknown ☐ X

Address: _____ City: _____ Province: _____ Postal Code: _____

Parent/ Guardian Name (Last, First): _____ Relationship to Client: _____

Telephone Number: _____ Mobile Number: _____ Email Address: _____

Language Spoken: _____ Interpreter Required: ☐ Yes ☐ No

REASON FOR REFERRAL

_____
_____
_____
_____
_____
_____
_____

REFERRING PROVIDER:

Name of Referring Provider (Last Name, First Name- as listed in CPSO): _____

Address: _____ City: _____ Province: _____ Postal Code: _____

Phone Number: _____ Fax Number: _____ CPSO #: _____ Billing (OHIP) #: _____

Signature: _____ Date: _____