STEVENSON MEMORIAL HOSPITAL

200 Fletcher Crescent
Alliston, Ontario L9R 1W7

PLEASE FAX REFERRAL TO:
705-797-0900
Phone: 705-797-0800

Out Patient Clinic: 705-435-6281 ext 2346

# *PEDIATRIC MEDICAL CONSULT REQUEST*

| **Name:** PRINT CLEARLY OR USE PATIENT LABEL **M / F** | **Health Card #:** |
|---|---|
| **Address:** | |
| **Phone #:** | **DOB:** (dd/mm/yy) |

**I would appreciate your opinion and/or on management regarding:** _____

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**Medications:**_____

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| ****Please send any appropriate labs, investigations, copy of CPP and growth charts with referral**** | |
|---|---|
| **Referring Physician Name:** | |
| **Referring Physician Signature:** | **Date:** |
| **Referring Physician Address:** | |
| **Phone #:** | **Fax #:** |