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:

Medications:

****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 #:**
Physician Billing #:	