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

REFERRAL FORM

Patient Information (Affix Label)

Last Name:
First Name:
Date of Birth:
OHIP#: VC:
Phone: H: C:

Expiry date:_____

Parents Email: _____

PLEASE SELECT THE SERVICE YOU ARE REQUESTING FOR YOUR PATIENT

☐ **General Paediatrics Consults**

Indicate reason:

- ☐ Medical concern
- ☐ Behavioural concern
- ☐ Developmental/Learning/school difficulty
- ☐ Language delay
- ☐ Motor skills concern
- ☐ ADHD Evaluation
- ☐ Gender Affirming Care

(as of February 2024 **Note: we do not provide primary care, 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 #:**_____

MD Address:_____ **Phone:**_____ **Fax:**

Signature:_____ **Today's Date:**

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