SickKids
Centre for Community Mental Health

Physician Referral Form

Name of patient: _____

Patient OHIP number: _____ Date of birth: _____
(dd/mmm/yyyy) ie 18 Jan 2019

Patient Address: _____
(please include full address, including postal code)

Parent's Name: _____ Parent's Phone #:_____

Primary referring physician's name: _____

Physician's billing code: _____

Physician's address: _____

_____

Physician's telephone: _____Fax number: _____

Reason for referral:

_____

_____

_____

Medical conditions:

_____

_____

_____

Medications:

_____

_____

440 Jarvis St.
Toronto, Ontario
Canada M4Y 2H4

1645 Sheppard Ave. W.
Toronto, Ontario
Canada M3M 2X4

www.sickkidscmh.ca

Allergies:

_____

_____

Known contraindications to psychotropic medications:

_____

_____
Signature of referring physician

Please return this form to:

SickKids Centre for Community Mental Health
Attn: Health Records Department
Fax # 416-373-2003

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Canada M4Y 2H4

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