Physician Referral Form-Peel Region

For children and youth under the age of 18

Information on the Child/Youth

Child/Youth First Name: _____ Last Name: _____

Date of Birth: _____ (Day) _____ (Month) _____ (Year) Gender: Male ☐ Female ☐ Other ☐:_____

Health Card No.: _____ Version Code: _____ Exp. Date: _____

Address: _____ (Apt./Unit #) _____ (Street) _____ (City/Town) ON (Province) _____ (Postal Code)

Child/Youth lives with: Both parents ☐ Mother ☐ Father ☐ Other ☐:_____

Who should be contacted for this referral?

Child/Youth: Yes ☐ No ☐ If no, who?: _____ Relationship to Child/Youth: _____

Phone No.: _____ Can messages be left? Yes ☐ No ☐

Reason for Referral *(please print clearly and check all that apply):*

Seeking a psychiatric consultation ☐ Seeking a diagnostic assessment ☐ Seeking mental health counseling/treatment ☐

Seeking a medication review ☐ Seeking a second opinion ☐

Other (specify): ☐

Required Physician Information

Physician Name:
Physician Address:
Physician Phone No.:
Physician Fax No.:
Billing No.:

Physician Office Stamp, if applicable:

Date of Referral: _____ (Day) _____ (Month) _____ (Year) _____ *Physician Signature*

FAX completed form to (905) 696-0352 or email to: info@wheretostart.ca
WhereToStart.ca Phone No.: (905) 451-4655