



Consultation Request

Date: _____

Please FAX request to (613)779-8686

Request Patient to be seen by:

- First Available Consultant
- Specific Paediatrician: _____

This request is:

- Medical – Urgent
- Medical – Routine
- Behavioural – Routine (until 16th birthday)

Patient Demographics + growth chart requested:

Name
DOB
HCN
Phone
Address
EMAIL

Reason for Referral: see attached

Referring Practitioner: _____ Billing # : _____