Pediatric Outpatient Program (POP) Clinic Referral Form

Please fax completed form to 705-740-8004

PATIENT LABEL

Level 6, Peterborough Regional Health Centre, 1 Hospital Drive, Peterborough, ON K9J 7C6
Phone: 705-743-2121 x. 8055 | Fax: 705-740-8004

- ☐ Newborn follow up clinic
- ☐ Neonatal follow up clinic
- ☐ RSV clinic
- ☐ Diabetic education clinic
- ☐ Behavioural Analyst
- ☐ Health & Wellness Program for kids and teens
- ☐ Chronic disease/infusion clinic
- ☐ Respiratory/asthma clinic
- ☐ Dietitian consult
- ☐ Lactation consult
- ☐ High risk antenatal consult/nas
- ☐ Rop consult
- ☐ Neonatal abstinence antenatal consult

Referring office: Please fax patient weight and growth charts with referral.

Patient Demographics

Child's Name: _____ Parent/Guardian Name: _____

Contact Number(s): _____ Custody: _____

Age: _____ Gender: ☐ M ☐ F ☐ Other, please specify: _____

Date of Birth (DD/MM/YYYY): _____ Health Card #: _____

Please ensure Health Card number and version code is up to date.

Referring Healthcare Professional: _____ *(please print)* Billing #: _____

MRP Signature: _____ Phone: _____ Fax: _____

Medical Information

Reason for referral/concern: _____

Primary diagnosis: _____

Other diagnosis: _____

Recent test/results: _____

Current medications: _____

One team, here when you need us most.
www.prhc.on.ca

Form #1633, Revised January, 2025

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Peterborough Regional Health Centre