PAEDIATRIC ACUTE REFERRAL SERVICE

☐ BGH Site
200 Terrace Hill St
Brantford, ON N3R 1G9
Tel: 519-751-5544 ext. 2380

* Clinic located on A4
(Inpatient paeds unit)

Fax: 519-751-5561

Name _____
Last First Initial

Address _____

Date of Birth _____
Day Month Year

Telephone: _____

Health Card # _____

Other ☐ _____

Parent Name:

Type of appointment: ☐ Community referral * ☐ ER Referral ☐ Discharge follow-up

For Community Referrals:
Name of Paediatrician On Service consulted for PARS Appointment Booking:

Level of Urgency: ☐ within 24hrs ☐ within 48hrs *If appointment required for greater than 48hrs please refer to community paediatrician

Please check off if patient has any of the following: ☐ **Respiratory** ☐ **Gastro** ☐ **Rash**

HISTORY AND CLINICAL INFORMATION MUST BE COMPLETED	**We need this information to provide a proper consultation for your patient. If using a fax to send the request, use the appropriate fax number above.**		
Referring Physician	*Important Please Print	Name: Phone Number: OHIP Number:	Signature
		Location: ☐ Community MD/NP ☐ ERP ☐ Paediatrician	

HEALTHCARD MUST BE PROVIDED AT TIME OF APPOINTMENT

****PLEASE FILL OUT APPOINTMENT TIME BELOW, TEAR OFF AND GIVE TO FAMILY****

PAEDIATRIC ACUTE REFERRAL SERVICE

Brantford General Hospital
4th Floor Paediatrics
200 Terrace Hill Street
Brantford, ON N3R1G9
519-751-5544 ext. 2380

***Please bring your child to the B-Wing 4th Floor Paediatric Department**

****YOU WILL BE CALLED THE NEXT DAY BY THE HOSPITAL WITH YOUR APPTOINTMENT TIME****

Your Child's Appointment Time is: _____. (please arrive 10 minutes early to register)

DIRECTIONS TO THE PAEDIATRIC ACUTE REFERRAL SERVICE CLINIC:

- Use the A-Wing elevator and go to the 4th floor
- Use the phone and call into the unit and identify to the staff you are there for an appointment
- Present to the Nurses Desk with your child's health card and our clerical support will register you