Mackenzie Health

Mackenzie Richmond Hill Hospital
10 Trench Street
Richmond Hill, Ontario
L4C 4Z3

Y: _____

Name: _____

Place Patient Barcode Label Here

Pediatric Urgent Care Clinic (PUCC) Referral Form

Telephone: 905-883-1212 **OR** 905-832-4554 Ext. 4957

Fax: 905-883-2213

Patient Information

Patient Name: *(Last, First)* Date of Birth: *(yyyy/mm/dd)*

Address: *Street No. & Name* *City* *Province* *Postal Code* *Country*

Main Telephone Number: Alternate Phone Number:

Health Card Number: Version Code:

Referring Physician

Physician Name: *(Last, First)* Physician Signature: Date: *(yyyy/mm/dd)*

Billing Number:

Telephone Number: Fax Number:

Address: *Street No. & Name* *City* *Province* *Postal Code* *Country*

Reason for Referral (select an option and provide details below)

☐ Respiratory illness ☐ Ongoing Fever ☐ Vomiting / Diarrhea ☐ Head injury ☐ Abdominal pain

☐ Other (please specify) _____

If patient is urgent, please call PUCC prior to faxing this form.

☐ High Priority will be seen within 24 hours Reason: _____

Non-urgent patients will be seen in PUCC within 72 hours.

For ER patients: Unit secretary to book patient using QES and give patient appointment date and time.

For outside offices: A member of the PUCC team will call the patient to schedule an appointment

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INSTRUCTIONS FOR STAFF

1. Give patient/family the PUCC instruction sheet.
2. Please fax this form and if applicable, ECG, Lab/DI results, urine POCT, consult notes and any other relevant information. Please check off which forms were attached below.

- ☐ ECG
- ☐ Lab/DI results
- ☐ Urine POCT
- ☐ Consult notes
- ☐ Additional forms (please specify) _____

For PUCC Office Use Only:

Appointment Date: _____ (yyyy/mm/dd)

Appointment Time: _____ (HH:MM)

Notify Patient:

- ☐ Appointment date and time confirmed with patient by PUCC
- ☐ Referring physician to notify patient of appointment date and time

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Pediatric Urgent Care Clinic

Patient Instruction Sheet

A referral for _____ (name) has been made to the Pediatric Urgent Care Clinic at Mackenzie Health. This involves an assessment by the Pediatric team within 24-72 hours. Please allow for approximately 2 hours for your entire appointment time.

☐ Appointment Date:_____ Time: _____
yyyy/mm/dd HH:MM

☐ You will be contacted with an appointment date and time

IF YOU ARE UNABLE TO KEEP THIS APPOINTMENT, please notify us as soon as possible at 905-883-1212 or 905-832-4554 Ext. 4957, so that we may schedule another patient.

- Please bring a complete list of all medications the patient is taking or has been prescribed.
- Please bring the patient's OHIP card and immunization record.
- Arrive 20 minutes prior to your appointment for Registration.
- Registration is on the main floor of the hospital, C wing, POD B, Room 2246
- After registering you will be directed to the clinic.

Please note: If your child's condition worsens prior to your scheduled appointment, please seek medical attention immediately.

Print Form