



Must complete all fields with to minimize delays on the referral of your patient. Fax to 905 521 8675

Child's Last Name: \_\_\_\_\_ Child's First Name: \_\_\_\_\_

Apt.: \_\_\_\_\_ Address: \_\_\_\_\_ City: \_\_\_\_\_

Prov.: \_\_\_\_\_ Postal Code: \_\_\_\_\_ Phone number: \_\_\_\_\_

Health Card # or IFH or UHIP: \_\_\_\_\_ Date of Birth: (dd/mmm/yyyy): \_\_\_\_\_

Name of Child's Birth Parent(s): \_\_\_\_\_

Name of Primary Care giver: \_\_\_\_\_

Name of Child's Service Worker (if applicable): \_\_\_\_\_

Person to Notify of Drs appt and Phone number: \_\_\_\_\_

Non-English patient/Care giver- Language spoken: \_\_\_\_\_ Interpreter required: yes ( ) no ( )

**Referring Physician/Agency:** \_\_\_\_\_ **Billing #:** \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Prov.: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Please attach the following with the SIS Clinic referral Sheet:

**For HIV Positive Children:**

- \*Positive HIV test
- \*Most recent CD4 and HIV Viral load results
- \*List of medications all meds (specially ARVs)
  
- \*HCV RNA and genotype (if applicable)
- \*Notes on Surgeries, learning and developmental issues and opportunistic infections, antiretroviral history and reason for any changes

**For Children of High risk mom mothers:**

- \*HIV PCR, HIV serology/P24 antigen at birth
- \*List of Medications (Antiretroviral)
- \*Mother's HIV PCR or serology, Syphilis, Hepatitis B & C results
- \*Was baby given antiretrovirals? If yes which one?
- \*Significant neonatal events (i.e. neonatal Opioid Withdrawal Syndrome)

*If patient is on any medication and is moving to this area, please ensure that a 3 month supply is provided*

\*\*\*Special Considerations/Comments\*\*\* \_\_\_\_\_

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Special Immunology Services (SIS Clinic)  
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