REFERRAL FORM

Boomerang Health is a paediatric clinic owned by The Hospital for Sick Children.
If unable to submit the form online, you may **fax the referral to 905-553-8120.**

Patient Information:

Last Name _____ First Name _____ Date of Birth MM DD YYYY

Health Card Number _____ Version _____ Gender _____ Email _____

Full Address _____ Phone Number (Home) _____

Caregivers' Names _____ Phone Number (Mobile) _____

Rehabilitation and Developmental Services:
Virtual Services Available

- ☐ Speech Therapy
- ☐ Occupational Therapy
- ☐ Nutrition/Dietitian
- ☐ Physiotherapy *(neurodevelopmental/orthopaedic)*
- ☐ Massage Therapy
- ☐ Psychology *(diagnostic assessment/psychotherapy*
- ☐ Social Work *(psychotherapy)*
- ☐ Group Therapy *(child/caregiver)*

See website for group information

Physician Services:
Virtual Services Available

- ☐ Consulting Paediatrics
- ☐ Primary Care
- ☐ Allergy
- ☐ Adolescent Medicine * *(including med consult)*
- ☐ Eating Disorders*
- ☐ Gender Affirming Care*
- ☐ Endocrinology
- ☐ Gastroenterology *(scope time available)*
- ☐ Nephrology
- ☐ Bladder & Bowel Dysfunction
- ☐ Neurology *(including epilepsy)*
- ☐ Headache Medicine *(please list all meds)*
- ☐ Sports Medicine
- ☐ Musculoskeletal Medicine

* *Referrals only for 12 years and older*

Reason for Referral:
If applicable, please ensure the following are included with the referral:

☐ Growth Charts ☐ Previous Blood Work ☐ Diagnostic Imaging ☐ Consultation Letters

Name of Referring Physician _____ Billing # _____ Signature _____

Address _____ Type of Medical Practice _____

Phone Number _____ Fax Number _____ Email _____ Date DD MM YYYY

SUBMIT

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Last Updated September 2021