Physician Referral Form

Transcend Youth Health

2686 Danforth Avenue
Toronto, Ontario M4C 1L7
T: (416) 849-2260
F: (416) 849-2261
info@transcendyouth.com
www.transcendyouth.com

PATIENT INFORMATION (AFFIX LABEL IF AVAILABLE)

Childs Last Name:
Childs First Name:
DOB (MM/DD/YYYY) **Gender:**
OHIP # **VC:**
Ph#
Email Parent 1:
Email Parent 2:

PLEASE SELECT THE SERVICE YOU ARE REQUESTING FOR YOUR PATIENT

Specialty Clinic:

□ Gender Affirming Care

○ Urgent ○ Not Urgent

REASON FOR REFERRAL

Please provide additional information regarding the reason for referral (specify current symptoms, presenting problems, relevant history and medications).

Referring MD_____

MD OHIP Billing # _____ *rejected without

MD Address: _____

Ph#: _____FAX #_____

MD Signature: _____

Todays Date:_____

Fax referrals to (416) 849-2261, response in 2-3 business days .

Located at Main Street and Danforth Ave. across from the Canadian Tire.