Dr. Shaneela Shahid - MD, FRCPC, FAAP, MSc
Consultant Pediatrician & Neonatologist
Pediatric Referral Form

Medical Information & Reason for Referral

Please provide a brief history, reason for consultation, positive physical findings, relevant investigations, and current medications

Please attach any relevant reports (if available)

Please indicate the preferred location for service: ☐MILTON

PATIENT INFORMATION – PLEASE COMPLETE		
Patient's Last Name: First		☐Mr. ☐Ms. ☐Mrs.
Home Address:	City:	Postal Code:
Email Address:	Home Phone: ( ) Mobile Phone: ( )	
Date of Birth:	OHIP Number:	
REFERRING PHYSICIAN - PLEASE COMPLETE		
Referring Physician (PRINT) . Address: . Physician Signature: . Billing Number: .	Backline Number: . Fax Number: . CC to Family Doctor (if different): . Family Doctor Phone: .	

Please Note: Our office will contact your patient directly with an appointment date and time.

PLEASE FAX ALL REFERRALS TO THE CENTRAL BOOKING LINE

Fax # (289) 270-2970

MILTON PEDIATRICS Clinic Line: 1- (905) 203 0624