NL Health Services

Child/Women's Health Program

General Pediatrics Central Intake Referral (Part I)

Email: genped.intake@easternhealth.ca Fax: 709-777-2790

See referring guidelines: https://cwhp.easternhealth.ca/for-health-professionals/

Incomplete referrals will be returned

AS7340 2461 04 2024

Name:

HCN:

Date of Birth:

Date: DD/MONTH/YYYY

Referring zone: ☐ Eastern (Rural) ☐ Eastern (Urban) ☐ Central ☐ Western ☐ Labrador Grenfell

Referring source information:

Name:_____ Telephone: _____ Fax: _____

Provider: ☐ Nurse Practitioner ☐ Physician ☐ Physiotherapist

Parent/Guardian information:

Name:_____ Address: _____

Primary Number: _____ Email: _____

Is an interpreter required to facilitate interactions: ☐ Yes ☐ No Language:_____

Schedule patient for next available Pediatrician: ☐ Yes ☐ No

If No, specify Pediatrician and reason:_____

Other services involved: ☐ Yes ☐ No (Check all that apply):

☐ Dietitian ☐ Speech-Language Pathology ☐ Physiotherapy ☐ Occupational Therapy

☐ Sub-Specialist/Clinician (specify): _____

Service requested: ☐ New Assessment **OR** ☐ Second Opinion

Reason for referral (Check all that apply):

Newborn Concerns (0-3 months) (Include Growth Chart):

☐ Failure to Thrive ☐ Plagiocephaly ☐ NICU Follow-up with active medical complexity

☐ Respiratory ☐ Symptomatic GERD ☐ Reflux

☐ Other (specify):_____

Cardiorespiratory Concerns;

☐ Asthma ☐ Chronic Cough ☐ Hypertension

☐ Pre-Syncope/Syncope ☐ Shortness of Breath ☐ Murmer-asymptomatic

☐ Other (specify):_____

Gastrointestinal/Urinary Concerns:

☐ Abdominal Pain ☐ Constipation ☐ Diarrhea ☐ GER/Vomitting ☐ Encopresis

☐ Enuresis ☐ Frequent Urination ☐ Hematuria: ☐ Microscopic ☐ Gross

☐ Proteineuria

☐ Other (specify):_____

Referring Source:

Name: _____ Signature: _____ Date:_____

NL Health Services

Child/Women's Health Program

General Pediatrics Central Intake Referral (Part II)

Email: genped.intake@easternhealth.ca Fax: 709-777-2790

See referring guidelines: https://cwhp.easternhealth.ca/for-health-professionals/

Incomplete referrals will be returned

AS7340 2461 04 2024

Name:

HCN:

Date of Birth:

Nutritional Concerns (Include Growth Chart):

☐ Iron Deficiency-symptomatic ☐ Poor weight gain ☐ Weight loss

☐ Symptomatic Anemia ☐ Selective eating

☐ Other (specify): _____

Other:

☐ Colic/Irritability/GER ☐ Headache/Migraine ☐ Short stature ☐ Gross motor delay (Pre-school age)

☐ Fatigue ☐ Syncope/Pre-syncope ☐ Dizziness ☐ Sleep concerns

☐ Other (specify): _____

Duration of symptoms: ☐ 0-3 months ☐ 3-6 months ☐ 6-12 months ☐ Greater than 12 months

Weight loss: ☐ Yes ☐ No

Any hospitalizations/emergency visits due to referring reason: ☐ Yes ☐ No

List any relevant medications:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

List any confirmed diagnoses:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Additional relevant information:

Submit Form

Referring Source:

Name: _____ Signature: _____ Date: _____