



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



Special Immunology Services (SIS Clinic)
690 Main Street West Hamilton, Ontario
L8S 1A4