

Pediatric Urgent Care Clinic (PUCC) Referral Form

Cortellucci Vaughan Hospital
3200 Major Mackenzie Drive West
Vaughan, ON L6A 4Z3
Telephone: 905-417-2000 Ext. 5490
Fax: 905-883-2213

Appointments will be arranged for 48-72 hours after date of referral. If patient needs to be seen earlier, please send referral as well as a phone call to the PUCC clinic.

Patient Information				
Patient Name: <small>(Last, First)</small>	Date of Birth: <small>(dd/mm/yyyy)</small>			
Address: #	<small>Street: No. & Name</small>	<small>City</small>	<small>Province</small>	<small>Postal Code</small> <small>Country</small>
Main Telephone Number:	Alternate Phone Number:			
Health Card Number:	Version Code:			
Referring Physician				
Physician Name: <small>(Last, First)</small>	Physician Signature:			Date: <small>(dd/mm/yyyy)</small>
Billing Number:				
Telephone Number:		Fax Number:		
Address:	<small>Street No. & Name</small>	<small>City</small>	<small>Province</small>	<small>Postal Code</small> <small>Country</small>
Reason for Referral <small>(select an option and provide details below)</small>				
<input type="checkbox"/> Respiratory illness <input type="checkbox"/> Ongoing Fever <input type="checkbox"/> Vomiting / Diarrhea <input type="checkbox"/> Head injury <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Other (please specify) _____ _____ _____				
<p>Please call and fax referral forms to PUCC.</p> <p>Urgent patients: will attempt to be seen in PUCC within 1-2 business days</p> <p>Non-urgent patients: will attempt to be seen in PUCC within 72 hours.</p> <p>For ER patients: Unit Secretary to book patient give patient appointment date and time for urgent referrals. For suspected or confirmed COVID patients, fax referral to PUCC. Patients will be contacted by PUCC with an appointment.</p> <p>For outside offices: A member of the PUCC team will call the patient to schedule an appointment.</p>				



Patient Urgent Care Clinic

Patient Instruction Sheet

A referral form _____ (patient name) has been made to the Pediatric Urgent Care Clinic at Mackenzie Health. This involves an assessment by the Pediatric team within 24-72 hours. Allow for approximately 2 hours for your entire appointment time.

Appointment Date: _____ Time: _____
dd/mm/yyyy

You will be contacted with an appointment date and time.

IF YOU ARE UNABLE TO KEEP THIS APPOINTMENT, please notify us as soon as possible at 905-417-2000 ex. 5490.

- Please bring a complete list of all medications the patient is taking or has been prescribed.
- Please bring the patient's OHIP card and immunization record.
- Arrive 20 minutes prior to your appointment for Registration.
- Please check in using our self-serve kiosks, located in Patient Registration Level 1 across from Main Entrance (Major Mackenzie Entrance)
- After registration you will be directed to the clinic

Please note: If your child's condition worsens prior to your scheduled appointment, take your child to the Emergency Department.