William Osler Health System

Brampton Civic Hospital
Women and Children's Paediatric
Outpatient Clinics, 3RD floor
2100 Bovaird Dr. East
Brampton, ON L6R 3J7
Phone: 905-494-6593
Fax: 905-494-6594

Patient Identification

Urgent Paediatric Assessment Clinic

Service Information: The Urgent Paediatric Assessment Clinic (UPAC) at Brampton Civic Hospital (BCH) provides timely specialized, follow-up care for paediatric patients, supporting early discharge from the Emergency Department (ED), Urgent Care Centre (UCC) and inpatient units. In partnership with the community family physicians enrolled in Seamless Care Optimizing Patient Experience (SCOPE) program, the clinic expedites referrals to UPAC, diverting non-urgent cases from the ED and UCC. Additionally, the UPAC clinic administers RSV prophylaxis for eligible pediatric patients at risk of RSV-related complications.

Referral Source ☐ED/ UCC ☐ Acute Care ☐ Primary Health Care ☐ Other_____

Inclusion Criteria (Check All that Apply)

☐ UTI greater than 3 months of age ☐ Jaundice less than one month of age, for follow-up ☐ Fever/rule out sepsis greater than two months of age ☐ Bronchiolitis with O2 saturations greater than 92% ☐ Asthma without O2 needs and PRAM score less than 2 ☐ Pneumonia with O2 saturations greater than 92% ☐ Feeding issues less than one month of age ☐ Cellulitis for re-assessment ☐ Gastrointestinal (stable on oral hydration needing reassessment) ☐ Seizure (stable 1st seizure/ febrile seizure) * Please call paediatrician on call before referring to UPAC

Exclusion Criteria (Check All that Apply)

☐CTAS levels 1 and 2 ☐Surgical abdomen (ruling out appendicitis) ☐Head trauma/head injury ☐Mental health/eating disorders ☐ Developmental Behaviour Disorder ☐Chronic disorders/ Issues (e.g., Headaches, Constipation)

Patient Information

Patient's Last Name: _____ **Patient's First Name:** _____

Date of Birth: (DD/MM/YY) _____ Gender: ☐ Male ☐ Female ☐ Other

Health Card Number: _____ **Version:** _____ **No OHIP:** ☐

Address: _____ **City:** _____**Province:** _____**Postal Code:** _____

Phone # (primary): _____ **Phone # (alternate):** _____ **Cell #:** _____

Patient's E-mail: _____ ☐ **Interpretation Services Required; Language:** _____

Person to contact for booking appointment *(If different than patient):* _____

Relationship to patient: _____

Reason for Referral & Relevant Patient History

Any clinical information that is required for booking appointments.

Referring Clinician Information

Referring Clinician Name: _____ **OHIP Billing Number:** _____

Phone #: _____ **Fax #:** _____ **E-mail:** _____

Family Physician *(If different from above)*: _____

Signature of Referring Clinician: _____ **Referral Date:** _____

01^REFERRAL

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