**SUNNY HILL HEALTH CENTRE**
**BC Children's Hospital**
**4500 Oak Street, Vancouver, BC V6H 3N1**
**REFERRAL FORM for**

**Phone: 604-875-2345**
**Toll Free: 1-888-300-3088**
**Fax: 604-453-8321**

# Early Motor Screening Program

**Date of Referral:** _____

CHILD'S NAME: _____ Gender: _____

Birthdate: (day/ month/ year): _____ PHN: _____ Child is a recent refugee? ☐ Yes ☐ No

Do they have an Interim Federal Health Certificate of Eligibility? ☐ Yes (Please send a copy) ☐ No

Address: _____ City: _____ Postal code: _____

Home Phone: (_____) _____ Work Phone: (_____) _____

Email Address: _____

Child lives with: Caregiver Name(s) _____ Relationship to Child _____

Legal Guardian Name(s): _____ Phone: (_____) _____

Legal Guardian Address: _____

City: _____ Postal code: _____ Language: _____ Interpreter required? ☐ Yes ☐ No

**Early Motor Screening Program Intake Criteria (Patient must meet ALL 5 criteria below)**

1. ☐ Patient is younger than 4 months corrected age, **AND**
2. ☐ Patient has NOT completed General Movements Assessment (GMA) during the fidgety phase, **AND**
3. ☐ Patient is NOT referred to the BC Women's Hospital Neonatal Follow-up Program (NFU), **AND**
4. ☐ Patient is NOT referred to another healthcare provider for GMA during the fidgety phase, **AND**
5. ☐ Patient demonstrates at least one of the risk factors below (check all that apply)

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| ☐ | Prematurity: < 32 weeks |
| ☐ | Very low birth weight: < 1500 g |
| ☐ | Cystic Periventricular Leukomalacia (PVL) |
| ☐ | Intraventricular Hemorrhage (IVH) Grade III-IV |
| ☐ | Neonatal meningitis |
| ☐ | Congenital CNS defects |
| ☐ | Moderate to severe neonatal Encephalopathy (including, but not restricted to: HIE, infectious encephalopathy) |

| | |
|---|---|
| ☐ | Postnatal meningitis |
| ☐ | Genetic abnormality associated with CP |
| ☐ | Placental abruption |
| ☐ | Apgar <7 at age 5 minutes |
| ☐ | History of stroke |
| ☐ | Severe traumatic brain injury requiring hospitalization or rehab, or any history of hospitalization due to encephalitis or bacterial meningitis, before the age of two years |

**Gestational Age at birth** (Mandatory Field): _____ weeks + _____ days

**Infant's current and/or working diagnosis:**

Referring Clinicians: (Print Name) _____

Department / Clinic Name: _____ Clinician's Signature: _____

Address: _____ (city) _____ (postal code) _____

Office telephone (_____) _____ Fax number: (_____) _____

Name of Family Physician (if known): _____

Pediatrician (if known): _____