



Date of Referral: _____

CHILD'S NAME: _____

Birthdate: (day/ month/ year) _____ Gender: _____

PHN: _____ Ambulatory Non-ambulatory 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: (_____) _____

Child lives with: Mother _____ Father _____ Foster Family _____

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

Legal Guardian Address: _____

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

Child's Current and/or Working Diagnosis:

Please identify Team / Service you are requesting:

- Assistive Technology Team (ATT)
- Feeding Team
- Hearing Team
- Tone Management (spasticity)
- Therapeutic Recreation: New Referral or Follow up from previous inpatient admission
- Aquatics: New Referral or Follow up from previous inpatient admission
- General Rehabilitation Clinic: New Referral or Follow up from previous inpatient admission
- Positioning and Mobility Team (PMT)
- Vision Team

Specific referral questions:

PLEASE ATTACH A COPY OF ALL PERTINENT CONSULTS, REPORTS AND MEDICAL INVESTIGATIONS

(ie: CT Scan, EEG, Labs – Chromosomes, Fragile X, Psychology Testing, Developmental Testing)

When referring to these services, the following additional information (if available) is required:

- ATT Services: **Audiologist, vision, OT & SLP reports**
- Feeding Services: **Growth charts & oromotor assessment**
- Positioning and Mobility and/or Tone services: **Orthopedic reports**
- Vision Services: **Ophthalmologist report**
- Hearing Services: **Audiologist report.**

REFERRING PHYSICIAN: (Print Name) _____

PHYSICIAN SIGNATURE: _____

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

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

Name of Family Physician: _____

Pediatrician: _____