SUNNY HILL HEALTH CENTRE **Phone: 604-875-2345**
BC Children's Hospital **Toll Free: 1-888-300-3088**
4500 Oak Street, Vancouver, BC V6H 3N1 **Fax: 778-504-9768**

THERAPIST REFERRAL FORM for NEUROMOTOR POSITIONING AND MOBILITY TEAM (PMT) SERVICES

Date of Referral: _____

CHILD'S NAME: _____ Birthdate: _____ Gender: _____
PHN: _____ ◯ Ambulatory ◯ Non-ambulatory
Interim Federal Health Program (IFHP)? ◯ No ◯ Yes, is copy attached to referral? ☐
At Home Program? ◯ Yes ◯ No Extended Medical? ◯ Yes ◯ No
Address: _____ City: _____ Postal code: _____
Primary phone: _____ Email: _____
Child lives with: Mother _____ Father _____ Foster Family _____
Legal Guardian Name(s): _____ Phone: _____
Legal Guardian Address: _____ City: _____ Postal code: _____
Is Legal Guardian aware of therapist's referral for SHHC service? ◯ Yes ◯ No
Primary Care Physician: _____ Physician is aware of therapist's referral? ◯ Yes ◯ No
Address: _____ City: _____ Postal Code: _____

Please indicate the PMT Specialized Service(s) you are requesting and describe your specific questions

☐ Mobility Assessment (Manual Wheelchair, Power Wheelchair, Stroller)

_____

_____

☐ Alternative Positioning (Walker, Standing Frame, Feeding Chair)

_____

_____

☐ Other: _____

_____

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

Child's Current and/or Working Diagnosis:

_____

The following information will be helpful, if available:
The PMT clinician will then follow up on this information during intake & assessment to determine next steps:

☐ Child is currently being followed by a Physician for medical concerns. If known, please explain:

☐ Child is currently being followed by a Physician for diagnostics. If known, please explain:

REFERRING THERAPIST: _____
THERAPIST SIGNATURE: _____
Address: _____ City: _____ Postal code: _____
Office telephone: _____ Fax number: _____

Please provide other team members' names & contact information on page 2.

COMMUNITY SERVICES	NAME	TELEPHONE NUMBER	EMAIL ADDRESS
School/Daycare			
Resource Teacher			
Occupational Therapist			
Physiotherapist			
Speech Language Pathologist			
OTHER(S):			

Parent/Legal Guardian Consent:
I hereby authorize the release of information from the above community therapists / services to Sunny Hill Health Centre's Positioning and Mobility Team (PMT)
This information about my child will be used to assist with PMT's intake, assessment and consultation.

SIGNATURE OF LEGAL GUARDIAN

DATE

If referral is not signed by legal guardian, referring professional must check BOTH boxes below:

☐ Referring professional confirms the legal guardian has consented to the referral.

☐ Referring professional confirms the legal guardian has consented for the above* community professionals to be contacted to assist with PMT's intake, assessment and consultation.

*Ensure to list names/contact details of community professionals.

FAX REFERRAL TO: 778-504-9768