Referral Form

Date Submitted:_____

Referrer Information

Submitted by:_____ Relationship to Child/Youth:_____

Referrer Phone:_____ Referrer Email:_____

Child/Youth Demographics

Name:_____ Date of Birth:_____

Gender:_____ Pronoun:_____

Address:_____

City:_____ Postal:_____

Youth Cell Phone:_____ Youth Email:_____

Child lives with:
Parent ☐ Foster Family ☐ Kinship Care ☐ Family Member ☐ Other:_____

Health Card Number:_____ Version Code:_____ Expiry:_____

Interpreter Required: Yes ☐ No ☐ Indicate Language:_____

Are you requesting services to be provided in French? Yes ☐ No ☐

Primary Diagnosis:_____ Given by:_____

Parent/Guardian Demographics

Name:_____ Relationship:_____

☐ Same address as child/youth

Address:_____

City:_____ Postal:_____

Contact Number Home:_____ Cell:_____ Work:_____

Preferred Contact: Home ☐ Cell ☐ Work ☐ Email:_____

Is the Parent/Guardian a legal guardian for the child/youth? Yes ☐ No ☐

If so, do they? ☐ make health decisions on behalf of the Child/Youth
☐ have rights to access information about the Child/Youth

Second Parent/Guardian Demographics

Name:_____ Relationship:_____

☐ Same address as child/youth

Address:_____

City:_____ Postal:_____

Contact Number Home:_____ Cell:_____ Work:_____

Preferred Contact: Home ☐ Cell ☐ Work ☐ Email:_____

Is the Second Parent/Guardian a legal guardian for the child/youth? Yes ☐ No ☐

If so, do they? ☐ make health decisions on behalf of the Child/Youth
☐ have rights to access information about the Child/Youth

Physician/Schools/Daycares

Family Doctor:_____ City:_____

School Name:_____ School Board:_____

Specify role, if referrer:_____ City or Town of School:_____

Daycare:_____ City/Town:_____

Services Requested

☐ **Augmentative Communication**: Support for developing alternative ways to communicate in person or in writing when speech or handwriting is not functional.

☐ **Autism and Behavioural Services**: Parents and caregivers must be registered in the Ontario Autism Program (O A P) to access treatment and free Foundational Family Services. Families may use the childhood budget or interim one-time funding to purchase treatment (behavioural, speech-language, or occupational therapies).

- ☐ **Bladder and Bowel Management**: Assessment and education of catheterization bowel/bladder management.
- ☐ **Blind Low Vision Early Intervention Program**: Early intervention support for families with children who are blind or have low vision from birth to school entry.
- ☐ **Brachial Plexus Treatment**: Acute therapy following obstetrical nerve injury to the upper extremity.
- ☐ **Occupational Therapy**: Assessment, intervention and consultation from birth to school entry.
- ☐ **Parent Mentor Services**: Work with families to develop/maintain effective relationships with child/youth's school by enhancing understanding, planning and problem solving.
- ☐ **Physiotherapy**: Assessment, intervention and consultation from birth to school entry.
- ☐ **Seating & Mobility**: Assessment, prescription and fitting of clients in need of seating support and mobility bases (strollers, wheelchairs, scooters).
- ☐ **Preschool Speech and Language Services** (includes: tykeTALK and Grey Bruce Preschool Speech and Language): Assessment, intervention and consultation from birth to school entry.
- ☐ **Splinting & Casting**: Fabrication of hand splints, ankle night splints and serial casting. Consultation with community OTs available for hand splinting.
- ☐ **Therapeutic Recreation/Adapted Recreation**: Offer opportunities and support for children and youth to develop and maintain skills, knowledge and behaviours in recreation and leisure areas.
- ☐ **Torticollis Treatment**: Acute therapy for infants presenting with decreased neck range of motion.
- ☐ **Youth Discovery Service**: Assist teens ages (12 years+) to plan their future, explore interests, hopes and dreams. Complements planning process at school with other agencies.
- ☐ **Youth Services**: Assist youth ages 12-21 to develop life skills, create meaningful connections with other youth, develop independence and gain new experiences.

Physician Requested

Physician referral required for the services below. May include PT, OT, SLP, SW and RN

Physician Name:_____ Family Physician? Yes ☐ No ☐

Referring Number:_____ Physician Fax:_____

Reason for referral (please be specific)

Child/Youth's Name:_____ Date of Birth:_____

☐ **Amputee Clinic**: Consult: Orthopaedics.

☐ **Cerebral Palsy Clinic**: For individuals with complex tone, seizures or feeding/swallowing issues. Consults: Neurology, Paediatrics, Gastroenterology and Physiatry.

☐ **Cleft Lip/Palate (CLP) and Oral Facial Anomalies Clinic**: Consults: Plastic Surgery, E.N.T., Paediatric Dentistry. Dentist/Orthodontic contact information is required.

☐ **Dental Funding Clinic**: Assessment of eligibility for funding for dental services for CLP, craniofacial anomalies, congenital oral defects and acquired facial/oral defects. Dentist/Physician referral and Dentist/Orthodontic contact information is required.

☐ **Neuromuscular Clinic**: Consults: Neurology, Orthopaedics, Respirology, Developmental Paediatrician and/or Genetics.

☐ **Paediatric Acquired Brain Injury Community Outreach Program**: Medical, educational and social support to children/youth who sustain brain injury after the age of 7 days in Middlesex, Oxford, Elgin, Huron and Perth.

☐ **Orthopaedic Clinic**: General

☐ **Orthopaedic Clinic**: Gait Lab

☐ **Developmental Paediatrics Consultation Clinic**: A consultative clinic offering diagnostic assessment and/or management recommendations. Child must present with concerns in at least two areas of development. Referrals must indicate the clinical question or area of need to be addressed, a description of what has already been tried to address the concern and supporting documentation (e.g., developmental screening, therapist/psychologist/school notes, prior pediatric or developmental assessments). Our clinic may provide initial support to implement a plan and amount of support will be based on need. Children will follow up with primary care for longitudinal care and health surveillance. Children can be re-referred if new questions arise.

☐ **Rett Syndrome Clinic**: Consults: Genetics, Neurology, Gastroenterology, Paediatrics and Physiatry.

☐ **Spina Bifida Clinic**: Consults: Neurology, Paediatrics, Orthopaedics, Urology and Physiatry.

☐ **Upper Extremity Clinic**: Consult: Plastic Surgery.

☐ **Velopharyngeal Dysfunction Clinic**: SLP assesses speech and resonance with further consultation from E.N.T. and Prosthodontics as appropriate.

Submitting Referral

Print and fax the completed forms to 519.685.8705

Print and mail forms to:

TVCC
Attention: INTAKE
779 Base Line Road East
London ON N6C 5Y6

Child/Youth's Name:_____ Date of Birth:_____