# 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 is 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.

**Tell us what is needed**

## 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:_____

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.
- ☐ **Modified Barium Swallow Assessment**: Conducted at Children's Hospital with a Radiologist to assess for aspiration. Fax referral to LHSC 519.685.8695. X ray requisition must accompany referral.
- ☐ **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
- ☐ **Paediatric Assessment Clinic**: Consult: Developmental Paediatrician. Paediatrician referral required.
- ☐ **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 this completed form 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:_____