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:______________________

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 the completed forms to 519.685.8705

Print and mail forms to:

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