Hamilton Health Sciences

Developmental Pediatrics and Rehabilitation Professional Referral Form

Ron Joyce Children's Health Centre
237 Barton Street E, Hamilton, ON L8L 2X2
Phone: (905) 521-7950 Fax: (905) 577-8029

Child's Last Name First Name

Address – Street City Postal Code

Date of Birth – (yyyy/mm/dd) Age Gender ☐ M ☐ F

HIN Version Code

PLEASE PRINT CLEARLY

Date of Request: (yyyy/mm/dd) _____ **Date last seen:** (yyyy/mm/dd) _____

Referral Source: Name: _____ Address: _____

Phone: _____ Fax: _____ Email: _____

If Physician: Signature: _____ OHIP Billing Number:_____

Family Physician: _____ Phone: _____

Substitute Decision Maker / Legal Guardian

Name	**Relationship to Patient**	**Contact Number**	**Best Time to call**
_____	☐ Parent ☐ Other - _____	_____	☐ AM ☐ PM
_____	☐ Parent ☐ Other - _____	_____	☐ AM ☐ PM

Do you require an interpreter? ☐ No ☐ Yes → what language? _____

Does the family receive Interim Federal Health Program funding (IFH)? ☐ No ☐ Yes

Reason for Referral (check all that apply) *Please include most recent assessment and any other relevant documentation.*

Service Requested

☐ Query Autism ☐ Infant Parent Program ☐ Physiotherapy
☐ Dev Ped Consult ☐ Early Childhood Resource ☐ Occupational Therapy
☐ Behaviour Therapy ☐ Speech and Language Therapy
☐ Seating Assessment, does the child use a wheelchair currently? ☐ Yes ☐ No ☐ Please Assess

Area of Concern **and describe** what the child is functionally unable to do as a result.

☐ Mobility/Gross Motor: _____
☐ Self Help/Fine motor _____
☐ Feeding: ☐ Picky eating (include number of foods currently eaten)_____
☐ Oral motor _____
☐ Sensory _____
☐ Communication: understanding and/or use of _____
☐ Other: _____

Additional Involvement:

School / Daycare: _____ Address:_____

Other services currently involved: ☐ CAS ☐ CCAS ☐ Early Words ☐ Other:_____

Other relevant diagnoses, conditions: _____

_____ ☐ Current Allergy List faxed with Referral

Relevant medical/psychiatric/safety concerns regarding the family:_____

_____

Please fax legibly completed referral form and any accompanying documentation to 905-577-8029. Incomplete forms will be returned to the referral source. Families will be contacted directly to book their appointment.