SCARBOROUGH CHILD DEVELOPMENT PROGRAM
REFERRAL FORM

Please complete all sections of this form.
Incomplete referrals will not be accepted.
For **Neonatal Follow Up,** please complete separate form available by calling the clinic.

Date of Referral (DD/MM/YYYY): _____

Is this referral being submitted with the knowledge and consent of the named parents/legal guardians?
❑YES ❑NO (if no, referral will not be processed)

Child's name: _____ _____
Last Name First Name Middle Name Date of Birth (DD/MM/YYYY)

❑Male ❑Female Health Card Number: _____ Version Code: _____

Address:

_____ _____ _____ _____ _____
Unit # Street # Street Name City Postal Code

Patient lives with: ❑Both parents ❑Mother ❑Father ❑Other - Specify: _____

Is there a custody arrangement? ❑NO ❑YES – joint custody ❑YES – sole custody of: _____

Interpreter required for communication with parents/guardians? ❑NO ❑YES - Language:_____

Parents/Guardians:

1) _____ ❑Mother ❑Father ❑Other: _____
Last Name First Name

Email: _____ Phone number: _____

2) _____ ❑Mother ❑Father ❑Other: _____
Last Name First Name

Email: _____ Phone number: _____

Reason(s) for Referral:
☐ Query Autism Spectrum Disorder:_____
☐ Global Development: _____
☐ Behavioural challenges:_____
☐ School difficulties:_____
☐ Other Concerns: _____

Specialty Requested:
❑ No preference/First available physician
❑ Developmental Paediatrician
❑ Paediatric Neurologist (for developmental assessment only)

Please note: Children 6 years and over can only be referred by paediatricians practicing in Scarborough and will be seen by the Developmental Paediatrician only.

Please complete both pages.

Significant medical history:_____
_____

Concerns to be addressed: _____
_____
_____
_____

Services Involved:

- ❑ Holland Bloorview Kids Rehabilitation Hospital
- ❑ Speech Therapy (Early Abilities)***
- ❑ Other: _____
- ❑ OT/LHIN
- ❑ Children's Aid

****Please note: We **strongly** recommend that preschoolers with language or social communication delays be referred to Early Abilities (Preschool Speech and Language Services). Families can also self-refer.*
Online: http://www.tph.to/earlyabilities By Phone: 416-338-8255 By Fax: 416-338-8511

Primary Care Provider: _____

Referring Physician:

Name (please print): _____ Billing Number:_____

Telephone: _____ Fax: _____

Physician's Signature:_____

Physician Stamp/Address:

Fax to: (416) 292-9678
Scarborough Child Development Program
2330 Midland Avenue
Scarborough, ON M1S 5G5
Phone: (416) 438-2911

N.B. *All families are strongly recommended to fill out the parent questionnaire and bring this with them to their first appointment. For children under six who are in daycare, preschool, or kindergarten, families should have the daycare/school complete the preschool questionnaire. Families of children six and older should have the child's school complete the school questionnaire. These questionnaires should also be brought to the first appointment.* **The questionnaires can be found at SHN.ca/paediatrics under Make a Referral.**

Internal Use Only Date Received (DD/MM/YYYY): _____

❑ Accepted by: _____ On (DD/MM/YYYY):_____

Accepted for: ○ Under six – first available ○ Under six – Developmental ○ Under six – Neurologist ○ Over six

❑ More information required: _____

- ○ Physician contacted on (DD/MM/YYYY): _____

❑ Declined - Reason: ○ Out of Catchment ○ Age ○ Reason for Referral

- ○ Other: _____
- ○ Physician notified on (DD/MM/YYYY): _____