Scarborough Kids Development Clinic
REFERRAL FORM

Reset Form

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

Child's legal guardian provided verbal/written consent to submit this referral
☐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

Phone # 1: _____ Phone # 2: _____Email: _____

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

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

Parent/Guardian:

_____ ☐Mother ☐Father ☐Other: _____
Last Name First Name

Reason(s) for Referral*±:
- ☐ Global Developmental Delay
- ☐ Query ASD
- ☐ Behavioural Challenges
- ☐ School Difficulties
- ☐ Suspected FASD (up to age 18 years)

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

** Children 6 years and over with developmental or behaviour concerns should be referred by paediatricians working at The Scarborough hospitals, and will be seen by the Developmental Paediatrician only.*

± For Neonatal Follow Up, please contact the clinic by phone.

Primary Concerns:

Medical History:

Services Involved:

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

****Please note:* We ***strongly*** *recommend referring preschoolers with language or social communication delays to Early Abilities (Preschool Speech and Language Services). Families can also self-refer. Online: http://www.toronto.ca/earlyabilities*

Primary Care Provider:

_____

Referring Physician:

Name: _____Billing Number: _____
Telephone: _____ Fax: _____

Physician's Signature: _____

Physician Stamp/Address:

Fax to (416) 292-9678
Mail to: Scarborough Kids Development Clinic
3050 Lawrence Ave. E.
Scarborough, ON M1P 2V5

Phone: 416-438-2911 ext 6120

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

☐ Accepted by _____ On (DD/MM/YYYY)_____

Accepted for: ☐Under age 6 years ☐FASD (up to age 18 years) ☐Over age 6 years

☐ 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): _____