ERINOAKKiDS
Centre for Treatment and Development

REFERRAL FORM

DATE OF REFERRAL REQUEST: _____

CLIENT INFORMATION

This request is being submitted with the knowledge and consent of named parents/legal guardians. Have parents provided implied consent to information collection as per the ErinoakKids Privacy Policy available at http:/www.erinoakkids.ca/Privacy?

Consent Received: ☐ Yes ☐ No If no, ErinoakKids will not process this referral.

Child's Name:

_____ _____ _____
Last *First* *Middle*

☐ **M** ☐ **F** **Date of Birth:** _____ _____ _____ **Health Card #:** _____ **Version Code:** _____
dd *mm* *yyyy*

Address:

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

Parent/Legal Guardian Names:

1. Person to Notify: *(primary contact – will be the only person notified for services)*

_____ _____ _____ Phone # 1: _____
Last *First* *Relationship* Phone # 2: _____
Email: _____

2. Next of Kin: *(secondary contact)*

_____ _____ _____ Phone # 1: _____
Last *First* *Relationship* Phone # 2: _____
Email: _____

Client Lives With? ☐ Both Parents ☐ One Parent ☐ Foster Parent ☐ Other (specify): _____

Children's Protective Services, Agency Name: _____

Caseworker: _____ Phone #: _____

Name any siblings who are receiving services at ErinoakKids: (first and last name of sibling(s)): _____

_____

Identify School Board, if applicable: _____

Primary Language(s) spoken in the home: _____

Are Interpreter services required? ☐ No ☐ Yes If yes, state language /ASL: _____

Allergies: ☐ No ☐ Yes **If yes, specify**_____

Epipen required? ☐ No ☐ Yes **If yes, specify the allergy**_____

Is this child receiving or waiting for services in the community? ☐ No ☐ Yes If yes, Identify the service(s) and agency name(s): _____

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Child's Name:_____

Diagnosis: ☐ No ☐ Yes If yes, identify: _____

Identified Issues/Areas of Concern:

_____

_____

_____

_____

SERVICE(S) REQUESTED

Services are provided for children with Physical or Developmental Disabilities, Autism and/or impairments with Communication, Hearing or Vision. Family must live in the catchment area of service.

Please visit our website at erinoakkids.ca/ourservices for detailed eligibility criteria and questionnaires where indicated.

Assistive Devices Resource Service (ADRS): (technology for home or home and school use. If technology is needed only for school, please follow up with your school for options).

Please complete the required questionnaire for each requested ADRS service. **erinoakkids.ca/adrs**

☐ Face to Face Communication *(attach Face to Face questionnaire)*
☐ Written Communication *(attach Writing Aid questionnaire)*
☐ Adapted Access: for Face to Face Communication technology *(attach Adapted Access questionnaire)*
☐ Adapted Access: to computer for non-writing activities (e.g. mouse control,switch access) *(attach Adapted Access questionnaire)*
☐ Adapted Access: for toys, Environmental Aids for Daily Living (EADL) *(attach Adapted Access questionnaire)*

Audiology Services:

☐ Infant Hearing Audiology
☐ Infant Hearing Screening:
- birth to 4 months: *(parent referral accepted)*
- 4 to 24 months: *(physician referral required and infant not previously screened)*

☐ Audiology - Fee for Service:
- birth to age 19 and/or not eligible through the Infant Hearing Program

Autism Services:

☐ Intensive Behavioural Intervention (IBI): *(attach diagnostic report that states Autism/ASD diagnosis)*

☐ Applied Behaviour Analysis (ABA):
- ErinoakKids Intake Services can assist with client registration for ABA-based Services and Supports or individuals can contact the Central West Region Intake for ABA-based Services and Supports directly at **1-800-668-6432**
- General inquiries can be directed to the Central West Region Intake for ABA-based Services and Supports at **1-800-668-6432.**

☐ **Medical Developmental Assessment** *(physician referral required)*

☐ **Occupational Therapy**

☐ **Physiotherapy**

☐ **Preschool Speech and Language**

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☐ **Query Autism Assessment** *(physician referral required)*

☐ **Respite Services:** refer to our website for information and the referral process for day and overnight Respite opportunities. *(attach the applicable questionnaire*) **erinoakkids.ca/respite**

☐ **Vision Services** *(attach diagnostic report of visual impairment)*

Referral Source:

☐ Parent/Guardian ☐ Medical ☐ Community Agency ☐ Other: _____

Referral Source Name and Contact information:

_____

_____ _____

Physician Referral Requirements:

A physician's referral is required for a Medical Developmental assessment, Query Autism assessment and for an Infant Hearing screening *(4-24 months and not previously screened).*

****Supporting documentation is required to support and proceed with a medical referral:
i.e., reports, tests/results, medical investigations, questionnaires.****

Physician's Name: _____ **Physician's Signature:** _____
(please print)

Tel #: _____ **Fax #:** _____ **Billing #:**_____

**Please fax the completed ErinoakKids referral form and documentation to:
ErinoakKids Intake Services
905-855-9451**