

REFERRAL FORM

Date of Referral Request: _____
dd mm yyyy

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 ErinoakKids Privacy Policy available at:
<http://www.erinoakkids.ca/About Us/Accountability/Privacy and Confidentiality>

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

Child's Name:

	<i>Last</i>	<i>First</i>	<i>Middle</i>
<input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth: _____		
	<i>dd</i>	<i>mm</i>	<i>yyyy</i>
Health Card #:			Version Code: _____
Address: _____			

<i>Unit #</i>	<i>Street #</i>	<i>Street Name</i>	<i>City</i>	<i>Postal Code</i>
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Parent/Legal Guardian Names:

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

<i>Last</i>	<i>First</i>	<i>Relationship</i>
Phone #1: _____	Phone #2: _____	Email: _____

2. Next of Kin *(secondary contact)*

<i>Last</i>	<i>First</i>	<i>Relationship</i>
Phone #1: _____	Phone #2: _____	Email: _____

Client Lives with: Both Parents One Parent
 Foster Parent Other *(specify)*:

Children's Protective Services, Agency Name: _____

Caseworker's Name: _____ Phone #: _____

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

(1) _____ (2) _____

Identify School Board, *if applicable*: _____

Primary Language(s) spoken in the home: _____

Are Interpreter Services required? Yes No

If Yes, state language / ASL _____

Allergies: Yes No If yes, specify: _____

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

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Child's Name: _____

Is this child receiving or waiting for services in the community? Yes No

If Yes, identify the service(s) and the Agency name(s): _____

Diagnosis: Yes No *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 www.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: www.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 - 2 months (parent referral accepted)
- Audiology – Fee for Service:
 - Birth to age 19 and/or not eligible through the Infant Hearing Program

Autism Services:

- Fee for Service - Autism Behavioural Intervention Services

Medical Services: (include all relevant reports)

- ASD Diagnostic Clinic – query autism assessments *(MD referral required)*
- Developmental Consultation Clinic – Clients with suspected or confirmed developmental or genetic delays/disorder requiring assessment/follow up *(MD referral required)*
- Neuromuscular Clinic – Clients with suspected or confirmed Neuromuscular Disorders requiring assessment/follow up *(MD referral required)*
- Orthopaedic Clinic – Clients with physical or developmental problems requiring surgical assessment and/or management of musculoskeletal problems *(MD referral required)*
- Botox - Clients with spasticity and or dynamic contractures that would benefit from Botox injection *(MD referral required)*

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- Occupational Therapy**
- Coordinated Service Planning**
- Physiotherapy**
- OHIP Pediatric Physiotherapy Clinic for the following diagnoses (*Physician referral required*)**
 - Torticollis
 - Tendinitis/Tendinosis
 - Muscle, ligament and tendon tears
 - Ligament sprains
 - Joint stiffness and pain
 - Repetitive strain injuries
 - Rheumatological issues ex. Juvenile Rheumatoid Arthritis
 - Rehabilitation after fracture
 - Sports and recreation injuries

Preschool Speech and Language – please complete the referral and online screening tool at www.erinoakkids.ca/communication-checkup

- Respite Services** - refer to our website for information and the referral process for day and overnight Respite opportunities – www.erinoakkids.ca/respite (*attach the applicable Questionnaire.*)
- Vision Services** (*attach diagnostic report of visual impairment*)

Referral Source:

- Parent/Guardian Medical Community Agency Other

Referral Source Name and Contact Information:

Physician's Referral Requirements:

A physician's referral is required for Medical Services, OHIP Pediatric Physiotherapy Clinic and for an Infant Hearing Screening (2 – 24 months and not previously screened).

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

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

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

Please Fax the completed 'ErinoakKids Referral Form' and all supporting documentation to:

ErinoakKids Intake Service: Fax 905.855.9451