REFERRAL REQUEST

Children's Treatment Centre
Quinte Health

How to refer:

- Please complete all fields and be sure to download/save the completed form to your computer/device to avoid submitting a blank form. If a blank or incomplete form is submitted using the secure upload method, there is no way to identify and notify the sender.
- Secure electronic upload (please see instructions on our website *www.quintectc.com*) ***or*** Fax to 613-968-9154

Questions? Call: 613-969-7400 ext. 2247

REFERRAL SOURCE INFORMATION

Name: | Profession/Role:

(*If Physician or Nurse Practitioner*) Registration Number: | Phone Number:

Address: | City: | Prov. | Postal Code:

Referral Date: *(dd-mmm-yyyy)*

CLIENT INFORMATION

Last Name: | First Name:

Health Card Number: | Version Code: | Expiry: *(dd-mmm-yyyy)*

Date of Birth: *(dd-mmm-yyyy)* | Gender: (select gender) | Primary Phone:

Address: | City: | Prov: | Postal Code:

PARENT/GUARDIAN INFORMATION

Primary Contact Last Name: | First Name:

Relationship to Child: (select relationship) *(if Other or Agency, please specify)*

(check all that apply) ☐ Legal Guardian ☐ Lives with Child ☐ I give consent for email communication

Primary Phone: | Other Phone: | email:

Address: ☐ Same as child's above-listed address ☐ Other than child's above-listed address *(if Other, provide below)*

Address: | City: | Prov: | Postal Code:

Second Contact Last Name: | First Name:

Relationship to Child: (select relationship) *(if Other or Agency, please specify)*

(check all that apply) ☐ Legal Guardian ☐ Lives with Child ☐ I give consent for email communication

Primary Phone: | Other Phone: | email:

Address: ☐ Same as child's above-listed address ☐ Other than child's above-listed address *(if Other, provide below)*

Address: | City: | Prov: | Postal Code:

265 Dundas St. E., Belleville, ON K8N 5A9 | https://quintectc.com
Tel: 613-969-7400 ext. 2247 | Fax: 613-968-9154

REFERRAL REQUEST

Child's Last Name: ***DOB:*** *(dd-mmm-yyyy)*

Child's First Name:

DECISION-MAKING RESPONSIBILITY

Decision-Making Responsibility: ☐ No formal agreement ☐ Formal Agreement in Place ☐ Parents live together with child

If formal agreement in place, please describe (eg. sole, joint, etc.):

If parents not together, all legal guardians are aware of and have consented to this referral: ☐ N/A ☐ Yes ☐ No

(if No, referral cannot be processed)

ADDITIONAL INFORMATION

Language(s) Spoken/Understood By Child: Interpreter required: ☐ Yes ☐ No

Diagnosis(es), *if any*:

Other services (eg. CAS, Infant & Child Development program, etc.):

School/Day Care (if known):

Voluntary Aboriginal Self-Identification ☐ First Nation ☐ Metis ☐ Inuit

AREA(S) OF CONCERN **(please describe what the child is functionally struggling with as a result)**

☐ Mobility/Gross motor:

☐ Self-help/Fine motor:

☐ Feeding:

☐ Speech, Language and/or Communication:

☐ Other:

SERVICE(S) REQUESTED

☐ Physiotherapy

☐ Occupational Therapy

☐ Feeding

☐ Autism Spectrum Diagnostic Assessment – MD/NP referral *required*

☐ Paediatrics (developmental and physical needs only) - MD/NP referral *required*

☐ Speech/Language Therapy

☐ Coordinated Service Planning (CSP) Program

☐ Fetal Alcohol Spectrum Disorder (FASD) Program

☐ SmartStart Hub *(please see website for details)*

AUTISM SPECTRUM DISORDER HUB

REFERRAL FOR PRIMARY CARE PRACTITIONERS AND NON-PAEDIATRICIANS

Children's Treatment Centre

Quinte Health

Child's Name:

DOB: dd/mmm/yyyy

- Complete all fields of the referral form
- If consult notes provide information requested in the "Clinical Observations" section, these may be attached instead; however, MUST contain clinical observations from the referral source that support the need for assessment
- Attach any required/completed reports, notes, or assessments, etc.
- Call 613-969-7400 x2264 for referral related inquiries
- Send referral using one of the following methods
- Mail to above address
- Fax to 613-968-9154
- Secure upload with Sync.com (for details consult *quintectc.com*)

Client Identification

Name | Date of Birth

Reason for Referral

What is your specific (diagnostic) question or primary reason for referral?

☐ I am requesting a second opinion. An ASD diagnosis was ☐ confirmed / ☐ ruled out at ☐ *(specify age)*

If requesting re-evaluation, please explain reason for request *(attach any current documentation, assessments, tests, etc. that now supports/rules out an ASD diagnosis)*

Clinical Observations/Rationale for Referral *(please see attached ASD criteria document for reference)*

☐ see consult notes attached

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Child's Name:

DOB: dd/mmm/yyyy

A. Additional concerns noted from parents/caregivers *(Check (✓) all that apply)*

- ☐ Loss of skills
- ☐ Anxiety
- ☐ Self-injurious behaviours
- ☐ Safety concerns
- ☐ Hyperactivity/Impulsivity
- ☐ Tantrums/aggression/negative/disruptive behaviour

Relevant Medical Information

List any other confirmed diagnoses

Relevant medical history and physical examination findings

Please list any other referrals that have been made for this child

Allergies

Medications – include alternative treatments, vitamins & herbal supplements, etc.

List imaging, lab work, tests and allied health assessments recently completed

Please attach all pertinent consult notes/reports

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