

Interprofessional Clinic Clinique Interprofessionnelle



Referral Form – Child Services

Fax # 613-526-7126

Child's Personal Information

First name	Last name	Date of birth (dd/mm/yyyy)	Age	Gender <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other	
Address	Apt.	City	Province	Postal Code	Preferred Pronouns
Primary Phone #	Secondary Phone #	Languages spoken <input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> Other (specify)			
Is your referral related to a specific diagnosis or any specific observations? <input type="checkbox"/> No <input type="checkbox"/> Yes (please specify)					
Source of referral (How did you hear about the clinic?) <input type="checkbox"/> Medical Referral <input type="checkbox"/> Online <input type="checkbox"/> Word of Mouth <input type="checkbox"/> Other:					
Any medical conditions or allergies? <input type="checkbox"/> No <input type="checkbox"/> Yes (please specify)				Insurance Coverage: <input type="checkbox"/> No <input type="checkbox"/> Yes	

Guardianship: Joint Sole (please specify): Other (please specify):

Parent/Guardian #1	Language: <input type="checkbox"/> En <input type="checkbox"/> Fr	Parent/Guardian #2	Language: <input type="checkbox"/> En <input type="checkbox"/> Fr
First name	Last name	First name	Last name
Phone #:	Relationship to the child	Phone #:	Relationship to the child

Reason for Referral: _____

The child shows difficulties with (select all that apply)

Completing daily activities: <input type="checkbox"/> Personal care (hygiene, dressing, eating) <input type="checkbox"/> Hobbies/ leisure (arts,sports, listening to music) <input type="checkbox"/> Academic activities <input type="checkbox"/> Social activities <input type="checkbox"/> Tasks at home/ chores
Listening and understanding/ comprehension: <input type="checkbox"/> Following conversations in noisy environments <input type="checkbox"/> Following instructions <input type="checkbox"/> Asks frequently for repetitions <input type="checkbox"/> Takes time to respond
Speaking: <input type="checkbox"/> Trouble finding words <input type="checkbox"/> Pronunciation/ articulation of sounds <input type="checkbox"/> Stuttering <input type="checkbox"/> Retaining information
Reading: <input type="checkbox"/> Decoding words <input type="checkbox"/> Text comprehension <input type="checkbox"/> Confuses letters
Writing: <input type="checkbox"/> Holding a pencil <input type="checkbox"/> Letter formation/ numbers <input type="checkbox"/> Organizing ideas <input type="checkbox"/> Grammar/ spelling
Physical aspects: <input type="checkbox"/> Posture <input type="checkbox"/> Balance <input type="checkbox"/> Strength <input type="checkbox"/> Coordination <input type="checkbox"/> Managing anxiety <input type="checkbox"/> Concentration/staying focused
Mathematics: <input type="checkbox"/> Comprehension of written problems <input type="checkbox"/> Mathematical equations

Other services (please specify)

Previous:
Current:
Waitlist:

Family Doctor

Referring Healthcare Provider

First & Last Name	First & Last Name
Address	Address
Telephone #	Telephone #