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) | 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

Home Phone: | Cell: | 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

Home Phone: | Cell: | 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)*