# 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)*

# AUTISM SPECTRUM DISORDER HUB

## REFERRAL FOR PRIMARY CARE PRACTITIONERS AND NON-PAEDIATRICIANS

Children's Treatment Centre
Quinte Health

Child's Last Name:

Child's First 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 electronic upload (for details consult *quintectc.com*)

**Client Identification**

Child's Last Name: Date of Birth: *(dd-mmm-yyyy)*

Child's First Name:

**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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# AUTISM SPECTRUM DISORDER HUB

## REFERRAL FOR PRIMARY CARE PRACTITIONERS AND NON-PAEDIATRICIANS

Children's Treatment Centre
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Child's Last Name:

Child's First 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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