

REFERRAL REQUEST

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 upload using Sync.com (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/yy) / /

CLIENT INFORMATION

Last Name: First Name:

Health Card Number: Version Code: Expiry: (dd / mmm / yy) / /

Date of Birth: (dd/mmm/yy) / / Gender: Phone: - -

Address: City: Prov: Postal Code:

PARENT/GUARDIAN INFORMATION

Primary Contact Last Name: First Name:

Relationship to Child: (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: (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:

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:

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

Physician/Nurse Practitioner Referral Required

- Physiotherapy
- Occupational Therapy
- Feeding
- Autism Spectrum Diagnostic Assessment
- Paediatrics (developmental and physical needs only)

No Physician/Nurse Practitioner Referral Required

- Speech/Language Therapy
- Coordinated Service Planning (CSP) Program
- Fetal Alcohol Spectrum Disorder (FASD) Program