Quinte Children's Treatment Centre
Quinte Health Care
Belleville General Hospital
265 Dundas Street East
Belleville, ON K8N 5A9

Telephone: **(613) 969-7400 x2247**
Fax: **(613) 968-9154**

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:

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

(check all that apply) ☐ Legal Guardian ☐ Custody ☐ Access to Health Record ☐ 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 ☐ Custody ☐ Access to Health Record ☐ 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)*

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Custody Arrangements

Custody Arrangements: ☐ No formal agreement ☐ Formal Agreement in Place ☐ Parents live together with child

Please Explain:

All legal guardians are aware of and have consented to this referral: (choose Yes or No) **(if no, referral cannot be processed)**

ADDITIONAL INFORMATION

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

Diagnosis(es), *if any*:

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

School/Day Care (if known):

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

No Physician/Nurse Practitioner Referral Required

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