KidsInclusive
EnfantsInclus
Centre for Child & Youth Development
Centre du développement des enfants et des adolescents

Kingston Health Sciences Centre
Centre des sciences de la santé de Kingston

REFERRAL FORM (PATIENT DEMOGRAPHIC INFORMATION)

ALL INFORMATION PROVIDED BELOW MUST BE COMPLETED BY THE REFERRING PHYSICIAN/AGENCY

Last Name: _____ First Name: _____

Address: _____ City: _____

Postal Code: _____ Email: _____

Home Phone # _____Unlisted _____ Gender: _____

Date of Birth: _____School: _____
dd/mmm/yyyy

Health Card # _____VC_____HC # Expiry Date:_____

Band# (Yes/No) #_____

Parent Information

Father's First Name: _____Last: _____

Mother's First Name: _____Last:_____

Guardian Status: _____ Name:_____

Work Contact Phone: _____(mom/dad) _____

Mailing address (**if not same as child's**):_____

Email:_____

Other Information:

Referring Physician/Agency: _____

Family Physician: _____

Reason for Referral: _____

_____

Note: Our Developmental Pediatricians do not provide primary care.

We are working to provide some services in French. Please check this box if the family requires services from KidsInclusive in French and we will do our best to accommodate your request. ☐

(Below is for KidsInclusive Office Use Only)

KidsInc. Chart # _____ CR #_____ Date Referred: _____

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REFERRAL CHECKLIST

IN ORDER FOR KIDSINCLUSIVE TO PROCESS ANY REFERRAL, THIS FORM MUST BE COMPLETED BY THE REFERRING PHYSICIAN. KIDSINCLUSIVE PROVIDES SERVICES FOR CHILDREN AND YOUTH WHO HAVE NEUROLOGICAL/PHYSICAL OR DEVELOPMENTAL DISABILITIES OR IMPAIRMENTS. IN ORDER TO ENSURE THE CHILD IS REFERRED TO THE MOST APPROPRIATE SETTING, PLEASE BE AS SPECIFIC AS POSSIBLE WITH THE INFORMATION YOU ARE PROVIDING.

PLEASE SPECIFY THE NATURE AND ONSET OF THE PROBLEMS YOU HAVE IDENTIFIED:

_____

_____

_____

PLEASE SPECIFY THE TYPE OF ASSESSMENT/TREATMENT BEING REQUESTED:

_____

_____

_____

DO YOU SUSPECT ANY OF THE FOLLOWING? PLEASE PROVIDE DETAILS OF CONCERNS:

Gross Motor Problems: _____
Cognitive Difficulties: _____
Fine Motor Problems: _____
Speech And Language Problems: _____
Cerebral Palsy: _____
Feeding Problems: _____
Autism Spectrum Disorder: _____
Other: _____

HAVE ANY OF THE FOLLOWING ASSESSMENTS/INVESTIGATIONS BEEN DONE OR CURRENTLY PENDING?

ASSESSMENT/INVESTIGATION	DATE	RESULT
Audiology		
Ophthalmology		
Neurology		
Psychology		
Genetics		
CT Scan		
Head U/S		
Chromosome Analysis		
Metabolic Screening		
Upper Gi / Swallow Study		

WHAT IS YOUR PRELIMINARY DIAGNOSIS?_____**HAVE YOU TOLD THE PARENTS?**_____

DOES THIS CHILD HAVE A DIAGNOSIS OF ASD (AUTISM SPECTRUM DISORDER)? ☐ **YES** ☐ **NO**
IF YES, WHAT IS YOUR CLINICAL QUESTION? (E.G. SLEEPING CONCERNS, EATING ISSUES, MEDICATION OPTIONS, ETC.):

_____

HAVE ANY OTHER AGENCIES BEEN INVOLVED (E.G. OTHER TREATMENT CENTRES, CHILDREN'S MENTAL HEALTH AGENCIES, CAS, INFANT DEVELOPMENT, ETC.)?

PLEASE SPECIFY:_____

COMMENTS:_____

SIGNATURE: _____