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

General Referral Form

CONFIDENTIAL

Fax to 613-545-3557 Questions? Call 613-544-3400 x 2078 or Toll Free: 1-855-544-3400 x 2078

A. Referral Source Information:		
Today's date(dd-mmm-yyyy):		
Name (referring individual):		Profession/Role:
If Physician/Nurse Practitioner – Registration #:		Phone #:
Address:	City:	Postal Code:

B. Child/Youth Information:		
Last Name:	Legal Name:	Chosen Name:
Date of Birth (dd-mmm-yyyy):	Sex: ☐ Male ☐ Female ☐ Intersex	
Gender: ☐ Male ☐ Female ☐ Non-binary ☐ Other ☐ Transgender M to F ☐ Transgender F to M	Pronouns: __ he/him ☐ she/her ☐ they/them ☐ Other: _____	
Address:	City:	Postal Code:
Health Card #: VC		HC # Expiry Date:

C. Parent/Guardian Information:		
Parent/Guardian Name #1:		
Legal Guardian: ☐ Yes ☐ No	Relationship:	
Address: ☐ Same as child's above-listed address ☐ Other than child's above-listed address (if other, provide below)		
Address:	City:	Postal Code:
Home Phone #:	Cell Phone #:	
Parent/Guardian Name #2:		
Legal Guardian: ☐ Yes ☐ No	Relationship:	
Address: ☐ Same as child's above-listed address ☐ Other than child's above-listed address (if other, provide below)		
Address:	City:	Postal Code:
Home Phone #:	Cell Phone #:	
Custody (if applicable): ☐ Joint ☐ Sole ☐ No Agreement ☐ Formal Agreement ☐ Kinship ☐ Family & Children Services Comments/Details:		

D. Additional Information:
Language(s) Spoken/Understood by Child/Youth:
Interpreter required: ☐ Yes ☐ No
Indigenous Status: ☐ Yes ☐ No
Diagnosis(es), if any:
Other services involved:

E. Area(s) of Concern: Please describe what the child/youth is <u>FUNCTIONALLY</u> struggling with as a result.
Mobility/Gross motor:
Fine motor:

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Self-help skills:
Feeding:
Social skills:
Speech, Language and/or Communication:
Other:

F. Service(s) Requested:	
☐ Physiotherapy	☐ Occupational Therapy
☐ Speech-Language Therapy	☐ Infant & Child Development Program
☐ Assessment for Neuromuscular Disorder (NM)	☐ SmartStart Hub
☐ Assessment for Acquired Brain Injury (ABI)	☐ Coordinated Service Planning *
☐ Assessment for Global Developmental Delay (GDD)	☐ Augmentative Communication Services *
☐ Assessment for Autism Spectrum Disorder (ASD)	☐ OAP Urgent Response Services *
☐ Assessment for Fetal Alcohol Spectrum Disorder (FASD)	☐ FASD Worker Service *
☐ Assessment for Developmental Coordination Disorder (DCD)	☐ Feeding Clinic *
☐ Other (e.g. workshop):	☐ School-based Rehabilitation Services *

* Will need to complete separate referral form – please visit https://kidsinclusive.ca/ for additional forms.

G. Autism Spectrum Disorder Assessments Only - Additional Information:
What is your specific (diagnostic) questions or primary reason for referral?
Describe clinical observations/rationale for referral (e.g. social communication or restrictive repetitive behaviours observed):
Relevant medical history and physical examination findings:
Other referrals that have been made for child/youth:
Medications child/youth is currently taking:
List imaging, lab work, tests and allied health assessments recently completed:
☐ Please see consult note/report attached (if applicable)

Physician/Service Provider Signature