



Intake Referral Form

**** To accelerate the Intake process, please complete all sections to the best of your knowledge. ****

Child Information:

First name: _____

OHIP #: _____

Middle Name: _____

Version Code: _____ Expiry: _____

Last Name: _____

Language of service: _____

DOB (d/m/y): ____/____/____

Home language: _____

Gender: Male Female

Interpreter required? Yes No

Address: _____

Phone #: _____

Please confirm that parent/guardian is aware of the reason for referral and agrees to this referral:

Parent/guardian consent is **mandatory** for the OCTC to process this referral.

Reason for referral: (if child has been assessed, please state diagnosis and provide report)

Concerns about Developmental Delay

Concerns about Autism Spectrum Disorder

Physical Disability (Specify):

Other Concerns

Parent/Guardian Information: (if child does not reside with parents, please indicate below)

#1: _____

Relationship to child: _____

Address (if different from above):

Home #: _____

Cell #: _____

Work #: _____

#2: _____

Relationship to child: _____

Address (if different from above):

Home #: _____

Cell #: _____

Work #: _____

If parents are separated/divorced, who has custody (please circle):

Parent#1 Parent #2 Joint Other: _____

CAS Involvement? Yes No If yes, please provide contact info: _____

Areas of concern (please check all that apply):

Communication No concern

- Receptive language (understanding and following instructions)
 - Expressive language (using words to express needs, wants, thoughts)
 - Speech intelligibility (clarity, articulation/pronunciation)
 - Social communication (answering questions, engaging in conversations)
 - Unusual/repetitive language
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Motor Skills No concern

- Gross motor/coordination (learning motor activities expected for age such as walking or running)
 - Fine motor /hand use (accomplishing fine motor activities expected for age, such as picking up small objects, stacking blocks, using pencil/scissors)
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Behaviour No concern

- Hyperactivity (moves constantly, can't sit still)
 - Inattention (does not seem to listen when spoken to, distractible)
 - Impulsive behaviour (acts without thinking about consequences)
 - Difficulty regulating emotions, temper tantrums
 - Fears and anxiety
 - Aggressive behaviors toward self and/or toward others
 - Unusual/repetitive movements with body
 - Seeking or avoiding sensory experiences (touch, noises, taste, smells)
 - Unusual/repetitive interests
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Social and Play Skills No concern

- Not making eye contact
 - Not using facial expressions (e.g., smiling, frowning) and gestures (e.g., pointing, shaking head, waving)
 - Not engaging in interactive games, such as peek-a-boo and hide-and-seek
 - Not seeking the attention of others to show things
 - Little interest in children and play with friends
 - Little interest in, and use of toys
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Self-Care and Safety No concern

- Having difficulty learning independence skills as expected for age (e.g., eating, dressing, toileting, hygiene)
 - Having difficulty showing understanding of dangerous situations (e.g., traffic hazards, stranger awareness)
-

Medical Information:

Please list any past and current medical concerns: (please check all areas that apply)

| | Past | Current | | Past | Current |
|-------------------|--------------------------|--------------------------|-------------------|--------------------------|--------------------------|
| Prematurity | <input type="checkbox"/> | <input type="checkbox"/> | Hypertonia | <input type="checkbox"/> | <input type="checkbox"/> |
| Brain Injury | <input type="checkbox"/> | <input type="checkbox"/> | Hypotonia | <input type="checkbox"/> | <input type="checkbox"/> |
| Seizures | <input type="checkbox"/> | <input type="checkbox"/> | Feeding Concerns | <input type="checkbox"/> | <input type="checkbox"/> |
| Prenatal Exposure | <input type="checkbox"/> | <input type="checkbox"/> | Sleeping Concerns | <input type="checkbox"/> | <input type="checkbox"/> |
| Macrocephaly | <input type="checkbox"/> | <input type="checkbox"/> | Failure to Thrive | <input type="checkbox"/> | <input type="checkbox"/> |
| Microcephaly | <input type="checkbox"/> | <input type="checkbox"/> | | | |

Has the child been referred or seen by any of the following Medical Specialists? Please provide their contact information and attach reports if available. (please check all areas that apply)

| | Seen | Referred | | Seen | Referred |
|--------------------|--------------------------|--------------------------|------------------|--------------------------|--------------------------|
| Geneticist | <input type="checkbox"/> | <input type="checkbox"/> | Ophthalmologist | <input type="checkbox"/> | <input type="checkbox"/> |
| Neurologist | <input type="checkbox"/> | <input type="checkbox"/> | Audiologist | <input type="checkbox"/> | <input type="checkbox"/> |
| Orthopedic Surgeon | <input type="checkbox"/> | <input type="checkbox"/> | Other Specialist | <input type="checkbox"/> | <input type="checkbox"/> |
| Pediatrician | <input type="checkbox"/> | <input type="checkbox"/> | | | |

Medical Investigations:

If there have been any medical investigations for this child please attach copies of the results to this referral.

MRI EEG Microarray Fragile X Other

Please list any medications that the child is presently taking:

**** Please attach a growth chart for the child to this referral. (if available) ****

Therapy Intervention:

Has the child received an assessment or treatment from any of the following?

Please attach reports and contact information if available. (please check all areas that apply)

| | Assessment | Treatment |
|-----------------------------|--------------------------|--------------------------|
| Speech Language Pathologist | <input type="checkbox"/> | <input type="checkbox"/> |
| Occupational Therapist | <input type="checkbox"/> | <input type="checkbox"/> |
| Physiotherapist | <input type="checkbox"/> | <input type="checkbox"/> |
| Psychologist | <input type="checkbox"/> | <input type="checkbox"/> |

Referral Source Information

Name of referral source: _____

Relationship to child: _____

Signature : _____ Date: _____

****Please note: OCTC requires a Medical Referral for a child (under age 3) to see a
Developmental Pediatrician****

Additional Information:

Please fax completed referral to 613.738.4841

Email: intake@octc.ca

Mailing Address: Intake Services

Ottawa Children's Treatment Centre

395 Smyth Road

Ottawa, ON K1H 8L2

If you have any questions, you may contact Intake Services at 613.737.0871 x 4425