ERINOAKKIDS
Centre for Treatment and Development

R E F E R R A L   F O R M

Date of Referral Request: ______________________
dd mm yyyy

CLIENT INFORMATION

This request is being submitted with the knowledge and consent of named parents/legal guardians.

Have parents provided implied consent to information collection as per ErinoakKids Privacy Policy available at: http/www.erinoakkids.ca/About Us/Accountability/Privacy and Confidentiality

Consent Received: ☐ Yes ☐ No If No, ErinoakKids will not process this referral.

Child's Name:
____
Last *First* *Middle*

☐ M ☐ F Date of Birth: ______________________
dd mm yyyy

Health Card #: ______________________ Version Code: ______________________

Address:
____
Unit # *Street #* *Street Name* *City* *Postal Code*

Parent/Legal Guardian Names:

1. Person to Notify: *(primary contact – will be the only person notified for services)*

____
Last *First* *Relationship*

Phone #1: ______________ Phone #2: ______________ Email: ______________

2. Next of Kin *(secondary contact)*

____
Last *First* *Relationship*

Phone #1: ______________ Phone #2: ______________ Email: ______________

Client Lives with: ☐ Both Parents ☐ One Parent
☐ Foster Parent ☐ Other *(specify):*

Children's Protective Services, Agency Name: ______________________

Caseworker's Name: ______________________ Phone #: ______________

Name any Siblings who are receiving services at ErinoakKids: *first and last name of sibling(s)*
(1) ______________________ (2) ______________________

Identify School Board*, if applicable:* ______________________

Primary Language(s) spoken in the home: ______________________

Are Interpreter Services required? ☐ Yes ☐ No

If Yes, state language / ASL: ______________________

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Child's Name: ____________________

Allergies: ☐ Yes ☐ No If yes, specify: ____________________

Epipen required? ☐ Yes ☐ No If yes, specify the allergy: ____________________

Is this child receiving or waiting for services in the community? ☐ Yes ☐ No

If Yes, identify the service(s) and the Agency name(s):

Diagnosis: ☐ Yes ☐ No *If Yes, identify:*

Identified Issues/Areas of Concern: ____________________

SERVICE(S) REQUESTED

Services are provided for children with Physical or Developmental Disabilities, Autism and/or impairments with Communication, Hearing or Vision. Family must live in the catchment area of service.

Please visit our website at www.erinoakkids.ca/ourservices for detailed eligibility criteria and questionnaires where indicated.

☐ **Assistive Devices Resource Service (ADRS):** *(Technology for home, or home and school use. If technology is needed only for school, please follow-up with your school for options).*

Please complete the required questionnaire for each requested ADRS service: www.erinoakkids.ca/adrs

- ☐ Face-to-Face Communication *(attach Face-to-Face Questionnaire)*
- ☐ Written Communication *(attach Writing Aid Questionnaire)*
- ☐ Adapted Access: for Face-to-Face Communication Technology *(attach Adapted Access Questionnaire)*
- ☐ Adapted Access: to computer for non-writing activities (e.g. mouse control, switch access) *(attach Adapted Access Questionnaire)*
- ☐ Adapted Access: for toys, Environmental Aids for Daily Living (EADL*)* *(attach Adapted Access Questionnaire)*

☐ **Audiology Services:**

- ☐ Infant Hearing Audiology
- ☐ Infant Hearing Screening
  - Birth - 4 months (parent referral accepted)
  - 4 – 24 months: (physician referral required and infant not previously screened.
- ☐ Audiology – Fee for Service:
  - Birth to age 19 and/or not eligible through the Infant Hearing Program

☐ **Autism Services:**

- ☐ Intensive Behavioural Intervention (IBI) (*attach diagnostic report that states Autism/ASD diagnosis)*
- ☐ Applied Behaviour Analysis (ABA) *(attach diagnostic report that states Autism/ASD diagnosis)*

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☐ **Medical Services:** *(Physician referral required)*

☐Medical Developmental Assessment *(please include any relevant reports, lab results, etc.)*
☐Query Autism Assessment
☐Physical Medicine and Rehabilitation *(please include any relevant reports, lab results, etc.)*
☐Torticollis

Clinics:
☐ Botox
☐ Orthopaedic

☐ **Occupational Therapy**

☐ **Physiotherapy**

☐ **Preschool Speech and Language**

☐ **Respite Services -** refer to our website for information and the referral process for day and overnight Respite opportunities **– www.erinoakkids.ca/respite** ***(****attach the applicable Questionnaire.)*

☐ **Vision Services** *(attach diagnostic report of visual impairment)*

Referral Source:

☐ Parent/Guardian ☐ Medical ☐ Community Agency ☐ Other

Referral Source Name and Contact Information:

____

____

____

Physician's Referral Requirements:

A physician's referral is required for all Medical Services and for an Infant Hearing Screening *(4 – 24 months and not previously screened)***.**

****Supporting documentation is required to support and proceed with a medical referral, i.e. reports, test/results, medical investigations, questionnaires****

Physician's Name: ______________________ **Physician's Signature:** ______________________
(please print)

Tel #: ________________ **Fax #:** ________________ **Billing #:** ________________

Please Fax the completed 'ErinoakKids Referral Form' and all supporting documentation to:

ErinoakKids Intake Service: Fax 905.855.9451