

**Office Use Only:**

Date received: \_\_\_\_\_\_\_\_\_\_\_\_

Sharevision: \_\_\_\_\_\_\_\_\_\_\_\_\_

**OCCUPATIONAL THERAPY REFERRAL FORM**

5050 47th Avenue

Delta, BC V4K 0C8

⬜ Urgent; reason for urgency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of referral:

**CHILD’S INFORMATION**

Child’s Name: Date of birth: ⬜ M / ⬜ F

Address: City:

Postal Code: Care Card #:

Mother/Father: Phone (H): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(C):

E-mail:

Mother/Father: Phone (H): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(C):

E-mail:

Child’s present status: ⬜ Natural ⬜ Adopted ⬜ Foster ⬜ First Nations ⬜ Other; describe

Social Worker (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Postal Code:

Language spoken in the home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Interpreter Required ⬜ Yes ⬜ No

Are there any cultural or religious observances of which we should be aware?

Do you have any information that may indicate a potential risk to a home visitor?

**BIRTH HISTORY:**  Birth Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gestational Age:

**REFERRAL INFORMATION:**

**SOURCE OF REFERRAL** ⬜ IDP ⬜ AIDP ⬜ SCD ⬜ ASCD ⬜ PHYSICIAN ⬜ PARENT ⬜ OTHER

Name of referral source: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Postal Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **REASON FOR REFERRAL:**

|  |  |
| --- | --- |
| * Swallowing concerns
 | * Equipment needs or positioning
 |
| * Self-care concerns (circle applicable): sleep, diet, self-feeding, toileting, dressing, other
 | * Fine motor concerns
 |
| * Sensory concerns
 | * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |

**DETAILS OF CONCERNS:**

**MEDICAL INFORMATION:**

Diagnosis (if applicable):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Family Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pediatrician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other Physicians Involved: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hearing tested⬜ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Vision tested⬜Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Additional Medical Concerns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OTHER PROGRAMS/SERVICES INVOLVED:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Service** | **Previous** | **Current** | **Waitlist** | **Contact** | **Phone** |
| B.C. Children’s Hospital and/or Sunny Hill |  |  |  |  |  |
| Developmental/Behavioural Assessment  |  |  |  |  |  |
| Infant Development Program or Aboriginal IDP |  |  |  |  |  |
| Supported Child Development or Aboriginal SCD |  |  |  |  |  |
| Speech-Language Therapy |  |  |  |  |  |
| Physiotherapy |  |  |  |  |  |
| Private Therapy Services (i.e. Autism Program, Alternative Health) |  |  |  |  |  |
| Other (i.e. preschool, daycare) |  |  |  |  |  |

**Please attach any relevant documentation such as assessments or reports.**

|  |
| --- |
| I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (legal guardian) give my permission for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to be seen by a *Reach Child and Youth Development Society* Occupational Therapist (OT), for the purpose of assessment and intervention. (If this child is in foster care, please have the child’s guardianship social worker sign.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *Signature of Legal Guardian Date* |
| Reach and The Centre for Child Development both provide occupational therapy services to families in Delta. There is one coordinated waitlist for services. Please select **one** of the two options and **sign below**:⬜ **Yes,** I consent to this completed referral form and any consultation records being shared with The Centre for Child Development’s Occupational Therapy (OT) Department for the purposes of waitlist management and service coordination. I understand that when my child’s name reaches the top of the waitlist, I will be offered OT services at Reach or at The Centre for Child Development, whichever is available at that time. I will be contacted at that time and will be given the choice to begin receiving services from the agency with the available spot or to wait to receive services from the other agency when a spot becomes available. * **No,** I do not consent to the information on this completed referral form being shared with The Centre for Child Development’s Occupational Therapy Department. I am aware that by selecting this box, I am choosing to wait to receive OT services from Reach.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *Signature of Legal Guardian Date* |