



# REFERRAL FORM

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*The John McGivney Children's Centre provides rehabilitative services to the Essex County community, enriching the lives of children and youth with disabilities and special needs by helping them reach their full potential.*

Client Name: \_\_\_\_\_  M  F  
Last Name First Name

DOB (day/month/yr): \_\_\_\_\_ Health Card #: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Telephone (home): \_\_\_\_\_ Telephone( work  cell): \_\_\_\_\_

School: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

**Diagnosis:** \_\_\_\_\_

### Referral Objectives:

**PLEASE NOTE:**  
The family physician will continue to have responsibility for ongoing general medical treatment. The Centre reserves the option of obtaining a comprehensive assessment or other appropriate consultation.

### What are your areas of concern:

\_\_\_\_\_

### Diagnostic Tests Completed/Pending:

- |                                     |                                      |
|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> Blood Work | <input type="checkbox"/> X-rays      |
| <input type="checkbox"/> Hearing    | <input type="checkbox"/> MRI/CT Scan |
| <input type="checkbox"/> Vision     | <input type="checkbox"/> EEG         |
| <input type="checkbox"/> Genetics   | <input type="checkbox"/> Psychology  |

Other Agencies Involved:  Children First  CAS  NICU follow-up clinic  Other \_\_\_\_\_

Current Medication: \_\_\_\_\_

**Who is making this referral:** \_\_\_\_\_ **Relationship to Client:** \_\_\_\_\_

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

**Telephone:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Form Completed by:** \_\_\_\_\_

### Other Relevant Information:

\_\_\_\_\_