



PHYSICIAN REFERRAL FORM

Visit us at our temporary location during construction:
 12050 Arbour Street
 Tecumseh, Ontario N8N 1N8
 (Former St. Anne High School)
 T: 519.979.7788
 Toll Free: 1.800.976.JMCC
 F: 519.979.0578
 www.jmccentre.ca

Client's Name: _____ M F
Last Name First Name

DOB (day/month/yr): _____ Health Card #: _____

Parents Name: _____

Home Address: _____ City: _____ Postal Code: _____

Telephone (home): _____ Telephone (work): _____

School: _____ Primary Care Physician: _____

Diagnosis: _____

Referral Objectives: _____

PLEASE NOTE: Non JMCC clients will not be eligible for referral to Medical Director only. Assessment will determine necessary intervention. Intervention may include Occupational Therapy, Physiotherapy, Communication Therapy, Social Work and/or consult with Medical Director. 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 on any patient referred.

Identify areas of concerns

| | | | | | |
|--------------------------|-------------|--------------------------|---------------------|--------------------------|------------------------------|
| <input type="checkbox"/> | Gross motor | <input type="checkbox"/> | Musculoskeletal | <input type="checkbox"/> | Feeding/eating |
| <input type="checkbox"/> | Fine motor | <input type="checkbox"/> | Speech and language | <input type="checkbox"/> | Other (please specify below) |

Request for Specialized Services

| | | | | | |
|--------------------------|-----------------------------------|--------------------------|-----------------------------|--------------------------|-----------------------------|
| <input type="checkbox"/> | Augmentative Communication Clinic | <input type="checkbox"/> | Seating and Mobility Clinic | <input type="checkbox"/> | Maxillofacial Speech Clinic |
|--------------------------|-----------------------------------|--------------------------|-----------------------------|--------------------------|-----------------------------|

Diagnostic Tests Done (please specify dates completed and attach results)

| | | | |
|--------------------------|--------------------|--------------------------|-----------------------------|
| <input type="checkbox"/> | Chromosomes | <input type="checkbox"/> | EEG |
| <input type="checkbox"/> | DNA | <input type="checkbox"/> | C-Spine x-ray (torticollis) |
| <input type="checkbox"/> | Metabolic work up | <input type="checkbox"/> | MRI / CT Scan |
| <input type="checkbox"/> | Other blood work | <input type="checkbox"/> | Psychometric Assessment |
| <input type="checkbox"/> | Hearing Assessment | <input type="checkbox"/> | Vision assessment |

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

Current Medication: _____

Referring Physician: _____
Please Print Signature

Referring Physician # _____

Address: _____ Postal Code: _____

Telephone: _____ Date: _____

Other Relevant Information:

| | | | | | | | |
|--------------------------|-----------|--------------------------|-----------|--------------------------|---------|--------------------------|--------|
| <input type="checkbox"/> | Behaviour | <input type="checkbox"/> | Cognition | <input type="checkbox"/> | Hearing | <input type="checkbox"/> | Vision |
|--------------------------|-----------|--------------------------|-----------|--------------------------|---------|--------------------------|--------|