Children's Treatment Network

Children's Treatment Network of Simcoe York

Request for Specialty Assessment and Consultative Services

FAX (705) 792-2775

Date of Referral _____ (dd-mm-yyyy) **Shared Client Record ID Number** _____

Name _____ **D.O.B.**_____ **M** ☐ **F** ☐ **GMFCS** _____
(Surname) (First) (dd-mm-yyyy)

Address _____
(P.O Box) (Full Street Address – Include Unit/Apt Number) (Town/City) (Postal Code)

Telephone _____ ***HCN** _____ **Version Code**_____ **Diagnosis**_____

Name of Parent(s)/Guardian(s) _____ **Alternate Phone Number** _____
☐ Mother ☐ Father ☐ Guardian

Need for Interpreter ❑NO ❑YES **if YES, what language?** _____ **Family Physician** _____

School Child Attends _____ **Grade:** _____ **School Board:** ❑ N/A ❑ YRDSB ❑YCDSB ❑ Fr Catholic ❑ Other ❑ SCDSB ❑SMCDSB ❑ Fr Public

LOCAL TEAM ASSESSMENTS ARE REQUIRED PRIOR TO MAKING A REFERRAL TO A SPECIALTY ASSESSMENT AND CONSULTATION SERVICE.

IF LOCAL TEAM ASSESSMENTS ARE NOT COMPLETED, USE THE REQUEST FOR LOCAL TEAM SERVICES FORM AND REQUEST LOCAL TEAM SERVICES FIRST.

Service Being Requested	Required Reports and Assessments	Physician/HCN* Referral Required
☐ **Augmentative and Alternative Communication (ACCS)** Referrals only by SLP	☐ Guided Assessment for Daily Communication Partners, **and** ☐ Guided Assessment for Professionals (min. last 2 pages): ☐Attached or ☐ Scanned into ECR	Not Required
☐**Developmental Assessment (DACS)** Team Referral with a minimum of SLP involvement + Physician	Relevant reports and/or supporting documentation: ☐Attached, or ☐ Scanned into ECR	Required. Discuss your concerns with the Physician and forward the referral to Physician ☐ Referral has been forwarded to Physician
☐ **Seating and Mobility (SEAT)** Referrals only by OT or PT	☐Relevant Reports OR Seating Request Summary: ☐Attached, or ☐ Scanned into ECR	Not Required
☐ **Joint Management Botox©/Baclofan** Referrals only by OT, PT +Physician	Relevant reports and/or supporting documentation: ☐Attached, or ☐ Scanned into ECR	Required. Discuss your concerns with the Physician and forward referral to Physician ☐ Referral has been forwarded to Physician
☐ **Psychological Assessment** Referrals only by School Psychologists or Developmental Paediatrician	Relevant reports and/or supporting documentation: ☐Attached, or ☐ Scanned into ECR **NOTE: Referral MUST BE pre-approved by Dr. Jennifer Saltzman-Benaiah**	Not Required
☐ **CTN Medical Consult** Referrals only by Paediatricians	Relevant reports and/or supporting documentation ☐Attached, ☐ Scanned	☐Required. Physician to Refer Directly

List other Services Involved with Client and Family:

_____

_____

Youth/Family agrees with this Referral including the collection and sharing of information for the purposes of processing Referral. ☐Yes ☐ No

The Network Consent for the Sharing of Information among Child and Family Team members has been discussed and completed with the Youth/Family *(if yes, attach form)* ☐Yes ☐ No Who has provided the consent? ☐Client/Youth ☐Parent/Guardian ☐CAS

Youth/Family agrees to CTN's use of the email address for the purpose of communicating with the family about upcoming Network events & Educational opportunities. ☐Yes ☐ No **Contact email address:** _____

_____ _____ _____
Signature of Person Sending Referral *Print name & Professional Designation* *Date*

_____ _____ _____
Agency *Email Address* *Telephone*

REVISED: JANUARY-2016