Hôpital de Montréal pour enfants
Centre universitaire de santé McGill

Montreal Children's Hospital
McGill University Health Centre

Allied Health Services & BDB 0-7 Clinic
Centralized Intake Referral Form

1001, boul. Décarie, Suite A04-3140, Montréal, Québec, H4A 3J1
Telephone: (514) 412- 4496 Fax: (514) 412- 4136
Email: bdbci@muhc.mcgill.ca

Patient Information (please print) :

Date of birth (yyyy/mm/dd):		MCH File No.
Last name, First name		
Current address	City, Province	Postal Code
Phone number:	Other telephone number:	
Email	Language ☐ French ☐ English Other: __________ ☐ Interpreter needed	

Referral date (yyyy/mm/dd):

Please specify the following: *NB if child does not meet this criteria, please redirect the request to the family's residential sector CIUSSS / CISSS*

☐ Child resides within one of the following McGill RUISSS sectors: *Nunavik, Outaouais, Cree Territory, West-Central Montreal and the West Island of Montreal, Nord du Québec, Montérégie West, Abitibi-Temiscamingue*

AND/OR

☐ Actively followed by a tertiary service at the MCH (*e.g. Oncology*)

AND

☐ Presents with developmental delays associated with a complex medical condition and/ or complex psychosocial situation (e.g. DYP case) *Specify*:
____

AND/OR

☐ Previously followed by the NICU. *Specify* ____

Please describe your concerns:

Please attach any additional information on a separate page.

Please select appropriate evaluations and specify reasoning:

NB for an Audiology assessment only, please use Audiology referral form available online on the MCH Website

☐ **ASD Assessment** ☐ Parents have been informed of the suspicion of autism
☐ Significant social difficulties ☐ Communication limitations ☐ Unusual behaviour / play
☐ Other: ____

OR

☐ **Occupational Therapy** *Specify:* ____

☐ **Clinical feeding evaluation regarding feeding safety and oral-motor skills by OT**. *Please indicate your safety concerns regarding feeding*:
____

Needs a Videofluoroscopy: ☐ Yes *(if yes, please send request directly to radiology 514-412-4347)* ☐ No

☐ **Speech Language Pathology** *Specify:* ____

☐ **Physiotherapy** *Specify:* ____

OR

☐ **FASD Assessment** *Please specify the frequency, amount, duration and timing of prenatal alcohol exposure (PAE), signed or confirmed by the birth mother or other reliable source:* ____

Please indicate if child is on the wait list or followed by these community services: *Please specify name & coordinates*

☐ **CRDP** (Centre de réadaptation en déficience physique): ______________________________________
☐ **CRDI-TSA** (Centre de réadaptation en déficience intellectuelle et Trouble du spectre de l'autisme): ____________________
☐ **CLSC / CISSS / CIUSSS** (e.g. Agir Tôt): ______________________________________
☐ **Youth Protection Services** (e.g. DYP / Batshaw) *Please provide coordinates of delegate(s)*: ______________________
☐ **Other:** ____

Previous assessments: *Please include reports*

☐ Audio ☐ OT ☐ SLP ☐ Physiotherapy ☐ Psychology ☐ Psychiatry ☐ Other: ____________________

Referral Source:

Name of Referring Physician or Nurse Practitioner (please print):	License number:
Address:	
Telephone number:	Fax number:
Name of Treating Physician (if different):	
PARENTS ARE INFORMED AND AGREE TO THIS REFERRAL ☐	Signature: