Hôpital de Montréal pour enfants
Centre universitaire de santé McGill

Montreal Children's Hospital
McGill University Health Centre

Brain Development Behavior School-Age Clinic (age 7-17)
Centralized Intake Referral Form

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

Patient Information (please print):

Date of birth		**MCH File no.** **RAMQ:**
Last name, First name		
Current address	**City, Province**	**Postal Code**
Home telephone 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 patient's local 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-Ouest, Abitibi-Temiscamingue*

or

☐ Actively followed by related tertiary service(s) at MCH (*e.g. Neurology, Psychiatry, Oncology, etc.*), *specify*: _____

and

☐ Presents with neurodevelopmental delays/deficits associated with a complex medical condition and/ or complex psychosocial situation (e.g. DYP involvement) requiring tertiary evaluation *Specify:*_____

Please describe your concerns and age of patient at referral:

Please attach any additional information on a separate page.

Please select the appropriate evaluation requested, specify reasoning & provide required information:

☐ **ASD for tertiary diagnostic assessment ages 7-12** **(N.B. For patients aged 13 yrs. or over clinicians must use the ASD 13 Clinic form for referral)**

***NB, Patients referred by an external source must be referred first to their local CIUSSS to be triaged to the appropriate diagnostic clinic or service within the CIUSSS or appropriate hospital center. (Referrals will be sent to/ accepted by BDB only if they meet criteria for *tertiary* assessment)**

☐ Significant social difficulties ☐ Significant communication limitations ☐ Unusual, atypical or repetitive behavior/play/interests
☐ Other: _____ ☐ Medical condition: specify:_____
☐ Complex Psychosocial,specifiy:_____

or

☐ **Evaluation of complex ADHD** ☐ Psychology assessment from within the last 2 yrs. **required & must be attached** (IQ & academic testing)
☐ Medications and/or targeted interventions of at least 6 months duration have failed
☐ Medical condition impedes treatment /intervention: specify:_____

or

☐ **FASD Assessment** ***Required information:** *Please specify the frequency, amount, duration and timing of significant prenatal alcohol exposure, signed or confirmed by the birth mother or other reliable source:*_____

☐ N.B. Psychology assessment from within the last 2 yrs required & must be attached (IQ & academic testing)

Please indicate current medications, dosage & duration of treatment

Medication	Dosage	Duration (wks or mon/ yr)

Please indicate if child is on a wait-list or currently followed by these services: *Please specify names, coordinates & reports if appl.*

☐ **Youth Protection Services** (e.g. DYP / Batshaw) *Please provide coordinates of delegate(s):* _____
☐ CRDP or **CRDI-TSA- DP** (Centre de réadaptation en déficience intellectuelle & Trouble du spectre de l'autisme and or déficience physique): _____
☐ **CLSC / CIUSSS** (e.g. mental health or psychosocial services, etc.): _____
☐ **Psychiatry:** Specify & provide reports if available:_____
☐ **Psychology/Neuropsychology:** Specify & provide reports if available_____
☐ **Speech Language (SLP):** ☐ **Occupational Therapy:** ☐ **Audiology** ☐ **Other(s):**

Referral Source Information & Signature:

Name of Referring Physician or Nurse Practitioner (please print): License number:

Address:

Telephone number: Fax number:

Name of Treating Physician (if different): **Referring clinician SIGNATURE:**:

PARENT(S) AND/OR PATIENT (over 14 yrs) ARE INFORMED OF THIS REFERRAL AND AGREE ☐

Patient over age 14 yrs: ☐ authorizes our clinic to contact parent/guardian about referral & appointment **OR** ☐ **does NOT** authorize contact with parent/guardian,
Please provide direct contact info. for patient over 14: PT cell (____) _____-_____ PT Email:_____