

## Developmental Assessment and Consultation Services Referral

Phone: (905) 954-4011 Fax: (905) 773-7090

Child's Name:		Date of Birth (DD/MM/YYYY)	Sex:
Date of Referral:	Referred by (Service and Name):		HC #
Parent(s)/Guardian:			
Address:		Home Phone: (    )	
Postal Code		Work Phone: (    )	
<b>Reason for Referral:</b>			
<input type="checkbox"/> Global Developmental Delay	<input type="checkbox"/> Autism Spectrum Disorder	<input type="checkbox"/> Social Delays	
<input type="checkbox"/> Speech/Language Delays	<input type="checkbox"/> Visual/Perceptual Difficulties	<input type="checkbox"/> Behaviour	
<input type="checkbox"/> Fine/Gross Motor Delays	<input type="checkbox"/> Cognitive Delays		
<b>Psychosocial Issues:</b>			
<b>Other assessments/investigations and results:</b> <i>(by whom and date)</i>		Developmental:	
Hearing:		Speech:	
Vision:		OT:	PT:
Genetics:		Psych:	
<b>What observations have led to this referral?</b>			
<b>Have your concerns/questions been discussed with the family?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>Summary of current assessment:</b> (eg. HELP, Speech)		<i>(please attach all reports)</i>	
<b>Is this child receiving services elsewhere?</b> (ie. CAS, school, CCAC, EIS)			
<input type="checkbox"/> No <input type="checkbox"/> Yes - where?			
<b>Please add any additional information that will be of assistance to us.</b>			

