



Eastern Health

Children and Women's Health Program

Child Development Referral (Part I)

Janeway Children and Women's Health Program
300 Prince Phillip Drive, St. John's, NL A1B 3V6 Phone: (709)777-4957
Email: jcd.intake@easternhealth.ca



Name: _____

HCN: _____

Date of Birth: _____

Allergies: _____ No Known

Mailing Address: _____

Parent/Guardian Name: _____ Telephone Number: _____

Relationship to Child: _____ Address (if different than child): _____

Parent/Guardian Name: _____ Telephone Number: _____

Relationship to Child: _____ Address (if different than child): _____

Do you require an Interpreter? No Yes Language? _____

Children, Senior and Social Development (CSSD)

Is CSSD Involved? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Social Worker: _____	Telephone: _____
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Service Requested - Check (✓) all that apply

Occupational Therapy	Speech-Language Pathology	Physiotherapy
Pediatrician -	New assessment	Second Opinion

What is your specific (diagnostic) question or primary reason for referral?

Are there concerns about Autism Spectrum Disorder (ASD) Yes No If "yes", list these concerns:

Parent/Guardian is aware of and agrees to this referral? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is Primary health care provider aware of this referral? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No primary health care provider
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Name of provider: _____

List confirmed diagnoses:

List Medications (include alternative treatments, vitamins and herbal supplements):

Has the child had a hearing test? No Yes Results: _____ (attach if applicable)

Include any additional information/special considerations:

Referring Practitioner's: Name: _____ Signature: _____

Date and Time: DD/MONTH/YYYY HH:MM



Children and Women's Health Program

Child Development Referral (Part II)

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Name: _____

HCN: _____

Date of Birth: _____

Indicate what other services are involved:

Occupational Therapy	Speech-Language Pathology	Mental Health and Addictions Services
Social Work	Audiology	Pediatrician: _____
Physiotherapy	Child/Behaviour Management Specialist	
Other (please identify): _____		

For children younger than school age, have you made a referral to the **Direct Home Services Program (DHSP)**? (DHSP - Telephone: (709)752-4350 Fax: (709)752-4580)

No Yes If yes, date of referral: DD/MONTH/YYYY

Have you made a referral to **Strongest Families**? No Yes, Date of referral: DD/MONTH/YYYY

Areas of Concern

Communication	Cognitive	Social
<ul style="list-style-type: none"> Not talking Difficulty understanding Talking in single words Trouble pronouncing sounds Voice/resonance Immature grammar Stuttering Echolalia Stereotyped/repetitive language Other (please explain): _____ 	<ul style="list-style-type: none"> Delayed developmental milestones Poor academic achievement Early risks factors (e.g., drug/ alcohol exposure, trauma, attachment, please explain): _____ Other (please explain): _____ 	<ul style="list-style-type: none"> Concerns with play skills Difficulty with peer interactions Social Interaction skills Other (please explain): _____
<ul style="list-style-type: none"> Behaviour Decreased attention Impulsivity Hyperactivity Self-regulation challenges Rigidity Aggression Self-injury Repetitive behaviours 	<ul style="list-style-type: none"> Physical Delayed developmental motor milestones(e.g., head control, rolling, sitting, crawling, walking) Gross motor(e.g. hopping, jumping) Fine motor(e.g.using pencils,scissors) Balance/coordination Other (please explain): _____ 	<ul style="list-style-type: none"> Sensory Concerns Textures(e.g., food, clothing) Sounds Other (please explain): _____
<ul style="list-style-type: none"> Self-Care skills Feeding/eating Toileting Dressing Other (please explain): _____ 	<ul style="list-style-type: none"> Other Loss of skills/ regression Safety concerns Restricted diet Other (please explain): _____ 	

Referring Practitioner's Name: _____ Signature: _____

Telephone: _____ Date and Time: DD/MONTH/YYYY HH:MM