NL Health Services

CHILD/WOMEN'S HEALTH

Pediatric Rehabilitation
First Assessment Clinic Referral (Part I)

CL2460 2507 12 2024

Name:

HCN:

Date of Birth:

Parent/Guardian: _____ Telephone: _____

Client lives with: ☐ Both Parents ☐ Father ☐ Mother ☐ Guardian ☐ Other, specify: _____

Child protection involvement: ☐ Yes ☐ No

If yes, name of social worker: _____ Telephone: _____

Parent/Guardian is aware of and in agreement with referral to rehabilitation services: ☐ Yes ☐ No

Is an interpreter required: ☐ Yes ☐ No If yes, language(s) spoken: _____

Reason for referral (must include physical/motor impairment): _____

Primary area(s) of concern (must select at least 1):

☐ Abnormal muscle tone
☐ Decreased muscle strength
☐ Decreased range of motion
☐ Physical/motor skills (gross motor, fine motor)
☐ Loss of skill and regression

Additional area(s) of concern:

☐ Speech/language skills
☐ Eating and swallowing
☐ Developmental/cognitive skills

Confirmed diagnosis:

☐ Down Syndrome
☐ Cerebral Palsy
☐ Spina Bifida/Dysraphism
☐ Spinal Cord Injury
☐ Traumatic Brain Injury
☐ Neuromuscular Disorder
☐ Neurodegenerative Condition
☐ Stroke
☐ Genetic Syndrome significantly impacting motor function
☐ Musculoskeletal conditions significantly impacting motor function (i.e., Arthrogryposis/BPI)
☐ Other (with motor impairment)

Relevant medical/social history:

Medication: ☐ Yes ☐ No If yes, list:

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Pediatric Rehabilitation
First Assessment Clinic Referral (Part II)

CL2460 2507 12 2024

Name:

HCN:

Date of Birth:

Indicate what other services are involved:

- ☐ Speech Language Pathology
- ☐ Child/Behaviour Management Specialist
- ☐ Mental Health and Addictions Services
- ☐ Social Work
- ☐ Occupational Therapy
- ☐ Physiotherapy
- ☐ Neurology
- ☐ Audiology
- ☐ Genetics
- ☐ Psychology
- ☐ Pediatrician
- ☐ Other: _____

Referral completed by: _____

Professional designation if appropriate: _____

Telephone: _____ Email: _____

Signature: _____ Date: DD/MONTH/YYYY

Janeway Children's Rehab Clinic Office Telephone: 709-777-4853/4854
Send completed form to fax: 709-777-4677
Email: JWRehab.Intake@nlhealthservices.ca
Incomplete referrals will be returned

For Clinic Use Only

Referral received on: DD/MONTH/YYYY Intake discussion date: DD/MONTH/YYYY

Plan:

- ☐ More information required, to be rediscussed at later date
- ☐ Not appropriate referral for Rehab Services; referral source to be notified
- ☐ Book for:
  - ☐ First Assessment Clinic
  - ☐ Neuromuscular Clinic
  - ☐ Down Syndrome Clinic
  - ☐ Travelling Clinic: _____
- ☐ Refer to: _____

Name: _____ Signature: _____ Date: DD/MONTH/YYYY

Submit Form