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
Fax: (709)777-4955 Email: jcd.intake@easternhealth.ca

CD1060 2182 10 2020

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? ☐Yes ☐ No	Name of Social Worker:	Phone:

Service Requested - Check (√) all that apply

☐ Occupational Therapy ☐ Speech-Language Pathology ☐ Physiotherapy

Pediatrician - ☐ New assessment OR ☐ Second Opinion

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

Are there concerns about Autism Spectrum Disorder (ASD) ☐ Yes ☐ No

If you ticked "yes", please list these concerns:

Parent/Guardian is **aware of and agrees** to this referral? ☐Yes ☐ No	Is Primary health care provider aware of this referral? ☐Yes ☐No ☐ No primary health care provider Name of provider: _____

List confirmed diagnoses:

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

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

Please include any additional information/special considerations:

Referring Practitioner Name:_____ Signature: _____

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

Eastern Health
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Child Development Referral (Part II)

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Name:

HCN:

Date of Birth:

Indicate what other services are involved:

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

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)752-2580)
☐No ☐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
- ☐ Not talking
- ☐ Difficulty understanding
- ☐ Talking in single words
- ☐ Trouble pronouncing sounds
- ☐ Voice/resonance
- ☐ Immature grammar
- ☐ Stuttering
- ☐ Echolalia
- ☐ Stereotyped/repetitive language
- ☐ Other (please explain): _____

▪ Cognitive
- ☐ Delayed developmental milestones
- ☐ Poor academic achievement
- ☐ Early risks factors (e.g., drug/ alcohol exposure, trauma, attachment, please explain): _____
- ☐ Other (please explain): _____

▪ Social
- ☐ Play skills
- ☐ Difficulty with peer interactions
- ☐ Social Interaction skills
- ☐ Other (please explain): _____

▪ Behaviour
- ☐ Decreased attention
- ☐ Impulsivity
- ☐ Hyperactivity
- ☐ Self-regulation challenges
- ☐ Rigidity
- ☐ Aggression
- ☐ Self-injury
- ☐ Repetitive behaviours

▪ Physical
- ☐ Delayed developmental motor milestones(e.g., head control, rolling, sitting, crawling, walking)
- ☐ Gross motor(e.g. hopping, jumping)
- ☐ Fine motor
- ☐ Balance/coordination
- ☐ Other (please explain): _____

▪ Sensory Concerns
- ☐ Textures(e.g., food, clothing)
- ☐ Sounds
- ☐ Other (please explain): _____

▪ Self-Care skills
- ☐ Feeding/eating
- ☐ Toileting
- ☐ Dressing
- ☐ Other (please explain): _____

▪ Other
- ☐ Loss of skills/ regression
- ☐ Safety concerns
- ☐ Restricted diet
- ☐ Other (please explain): _____

Referring Practitioner Name: _____ Signature: _____

Fax: _____ Telephone: _____

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