Ottawa Children's Treatment Centre
Innovation. Motivation. Determination.

Intake Referral Form

**** To accelerate the Intake process, please complete all sections to the best of your knowledge. ****

Child Information:

First name: _____

Middle Name: _____

Last Name: _____

DOB (d/m/y): ____/_____/_____

Gender: ☐ Male ☐ Female

Address: _____

_____

_____

Phone #: _____

OHIP #: _____

Version Code: _____ Expiry: _____

Language of service: _____

Home language: _____

Interpreter required? ☐ Yes ☐ No

Please confirm that parent/guardian is aware of the reason for referral and agrees to this referral: ☐

Parent/guardian consent is **mandatory** for the OCTC to process this referral.

Reason for referral: (if child has been assessed, please state diagnosis and provide report)

☐ Concerns about Developmental Delay

☐ Concerns about Autism Spectrum Disorder

☐ Physical Disability (Specify):

☐ Other Concerns

_____

_____

Parent/Guardian Information: (if child does not reside with parents, please indicate below)

#1: _____

Address (if different from above):

_____

_____

Relationship to child: _____

Home #: _____

Cell #: _____

Work #: _____

#2: _____

Address (if different from above):

_____

_____

Relationship to child: _____

Home #: _____

Cell #: _____

Work #: _____

If parents are separated/divorced, who has custody (please circle):

Parent#1 Parent #2 Joint Other:_____

CAS Involvement? Yes No If yes, please provide contact info:_____

Areas of concern (please check all that apply):

Communication ☐ No concern

- ☐ Receptive language (understanding and following instructions)
- ☐ Expressive language (using words to express needs, wants, thoughts)
- ☐ Speech intelligibility (clarity, articulation/pronunciation)
- ☐ Social communication (answering questions, engaging in conversations)
- ☐ Unusual/repetitive language

Motor Skills ☐ No concern

- ☐ Gross motor/coordination (learning motor activities expected for age such as walking or running)
- ☐ Fine motor /hand use (accomplishing fine motor activities expected for age, such as picking up small objects, stacking blocks, using pencil/scissors)

Behaviour ☐ No concern

- ☐ Hyperactivity (moves constantly, can't sit still)
- ☐ Inattention (does not seem to listen when spoken to, distractible)
- ☐ Impulsive behaviour (acts without thinking about consequences)
- ☐ Difficulty regulating emotions, temper tantrums
- ☐ Fears and anxiety
- ☐ Aggressive behaviors toward self and/or toward others
- ☐ Unusual/repetitive movements with body
- ☐ Seeking or avoiding sensory experiences (touch, noises, taste, smells)
- ☐ Unusual/repetitive interests

Social and Play Skills ☐ No concern

- ☐ Not making eye contact
- ☐ Not using facial expressions (e.g., smiling, frowning) and gestures (e.g., pointing, shaking head, waving)
- ☐ Not engaging in interactive games, such as peek-a-boo and hide-and-seek
- ☐ Not seeking the attention of others to show things
- ☐ Little interest in children and play with friends
- ☐ Little interest in, and use of toys

Self-Care and Safety ☐ No concern

- ☐ Having difficulty learning independence skills as expected for age (e.g., eating, dressing, toileting, hygiene)
- ☐ Having difficulty showing understanding of dangerous situations (e.g., traffic hazards, stranger awareness)

Medical Information:

Please list any past and current medical concerns: (please check all areas that apply)

	Past	Current
Prematurity	☐	☐
Brain Injury	☐	☐
Seizures	☐	☐
Prenatal Exposure	☐	☐
Macrocephaly	☐	☐
Microcephaly	☐	☐

	Past	Current
Hypertonia	☐	☐
Hypotonia	☐	☐
Feeding Concerns	☐	☐
Sleeping Concerns	☐	☐
Failure to Thrive	☐	☐

Has the child been referred or seen by any of the following Medical Specialists? Please provide their contact information and attach reports if available. (please check all areas that apply)

	Seen	Referred
Geneticist	☐	☐
Neurologist	☐	☐
Orthopedic Surgeon	☐	☐
Pediatrician	☐	☐

	Seen	Referred
Ophthalmologist	☐	☐
Audiologist	☐	☐
Other Specialist	☐	☐

Medical Investigations:

If there have been any medical investigations for this child please attach copies of the results to this referral.

☐ MRI ☐ EEG ☐ Microarray ☐ Fragile X ☐ Other

Please list any medications that the child is presently taking:

_____

_____

_____

**** Please attach a growth chart for the child to this referral. (if available) ****

Therapy Intervention:

Has the child received an assessment or treatment from any of the following?
Please attach reports and contact information if available. (please check all areas that apply)

	Assessment	Treatment
Speech Language Pathologist	☐	☐
Occupational Therapist	☐	☐
Physiotherapist	☐	☐
Psychologist	☐	☐

Referral Source Information

Name of referral source: _____

Relationship to child: _____

_____

Signature : _____ Date:_____

****Please note: OCTC requires a Medical Referral for a child (under age 3)to see a Developmental Pediatrician****

Additional Information:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Please fax completed referral to 613.738.4841

Email: intake@octc.ca

Mailing Address: Intake Services

Ottawa Children's Treatment Centre

395 Smyth Road

Ottawa, ON K1H 8L2

If you have any questions, you may contact Intake Services at 613.737.0871 x 4425