SUNNY HILL HEALTH CENTRE
BC Children's Hospital
4500 Oak Street, Vancouver, BC V6H 3N1

Phone: 604-875-2345
Toll Free: 1-888-300-3088
Fax: 604-453-8321

PHYSICIAN REFERRAL FORM for NEUROMOTOR SERVICES

Date of Referral: ____________________

CHILD'S NAME: ____

Birthdate: (day/ month/ year)____Gender: ____________________

PHN: ________________________ ☐ Ambulatory ☐ Non-ambulatory Child is a recent refugee? ☐ Yes ☐ No

Do they have an Interim Federal Health Certificate of Eligibility? ☐ Yes (Please send a copy) ☐ No

Address:____

City:____Postal code:______________________________

Home Phone:(__________)_________________________ Work Phone: (________)_________________________

Child lives with: Mother_____________________Father____________________ Foster Family_______________

Legal Guardian Name(s):____Phone: (________) ____________

Legal Guardian Address:____

City:_______________ Postal code: ______________Language: ____________ Interpreter required? ☐ Yes ☐ No

Child's Current and/or Working Diagnosis:

Please identify Team / Service you are requesting:

☐ Assistive Technology Team (ATT)

☐ Positioning and Mobility Team (PMT)

☐ Feeding Team

☐ Vision Impairment Program

☐ Hearing Loss Team

☐ Tone Management (spasticity)

☐ Therapeutic Recreation: ☐ New Referral or ☐ Follow up from previous inpatient admission

☐ Aquatics: ☐ New Referral or ☐ Follow up from previous inpatient admission

☐ General Rehabilitation Clinic: ☐ New Referral or ☐ Follow up from previous inpatient admission

Specific referral questions:

PLEASE ATTACH A COPY OF ALL PERTINENT CONSULTS, REPORTS AND MEDICAL INVESTIGATIONS
(ie: CT Scan, EEG, Labs – Chromosomes, Fragile X, Psychology Testing, Developmental Testing)
When referring to these services, the following additional information (if available) is required:

☐ ATT Services: **Audiologist, vision, OT & SLP reports**

☐ Feeding Services: **Growth charts & oromotor assessment**

☐ Positioning and Mobility and/or Tone services: **Orthopedic reports**

☐ Vision Services: **Ophthalmologist report**

☐ Hearing Services: **Audiologist report.**

REFERRING PHYSICIAN: (Print Name)____

PHYSICIAN SIGNATURE: ____

Address:_________________________________(city)____________________(postal code)____________

Office telephone (____)__________________________Fax number: (_____)______________________________

Name of Family Physician: ____

Pediatrician: ____