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

THERAPIST REFERRAL FORM for NEUROMOTOR POSITIONING AND MOBILITY TEAM (PMT) SERVICES

Date of Referral: ____________

CHILD'S NAME: ____________ Birthdate: ____________ Gender: ____________
PHN: ____________ Ambulatory Non-ambulatory
Interim Federal Health Program (IFHP)? No Yes, is copy attached to referral?
At Home Program? Yes No Extended Medical? Yes No
Address: ____________ City: ____________ Postal code: ____________
Primary phone: ____________ Email: ____________
Child lives with: Mother ____________ Father ____________ Foster Family ____________
Legal Guardian Name(s): ____________ Phone: ____________
Legal Guardian Address: ____________ City: ____________ Postal code: ____________
Is Legal Guardian aware of therapist's referral for SHHC service? Yes No
Primary Care Physician: ____________ Physician is aware of therapist's referral? Yes No
Address: ____________ City: ____________ Postal Code: ____________

Please indicate the PMT Specialized Service(s) you are requesting and describe your specific questions

Mobility Assessment (Manual Wheelchair, Power Wheelchair, Stroller)

____

Alternative Positioning (Walker, Standing Frame, Feeding Chair)

____

Other: ____________

When referring to these services, the following additional information (if available) is required: OT & PT Reports

Child's Current and/or Working Diagnosis:

____

The following information will be helpful, if available:
The PMT clinician will then follow up on this information during intake & assessment to determine next steps:

Child is currently being followed by a Physician for medical concerns. If known, please explain:

Child is currently being followed by a Physician for diagnostics. If known, please explain:

REFERRING THERAPIST: ____________
THERAPIST SIGNATURE: ____________
Address: ____________ City: ____________ Postal code: ____________
Office telephone: ____________ Fax number: ____________

Please provide other team members' names & contact information on page 2.

COMMUNITY SERVICES	NAME	TELEPHONE NUMBER	EMAIL ADDRESS
School/Daycare			
Resource Teacher			
Occupational Therapist			
Physiotherapist			
Speech Language Pathologist			
OTHER(S):			

Parent/Legal Guardian Consent:
I hereby authorize the release of information from the above community therapists / services to Sunny Hill Health Centre's Positioning and Mobility Team (PMT)
This information about my child will be used to assist with PMT's intake, assessment and consultation.

SIGNATURE OF LEGAL GUARDIAN

DATE

If referral is not signed by legal guardian, referring professional must check BOTH boxes below:

Referring professional confirms the legal guardian has consented to the referral.

Referring professional confirms the legal guardian has consented for the above* community professionals to be contacted to assist with PMT's intake, assessment and consultation.

*Ensure to list names/contact details of community professionals.

FAX REFERRAL TO: 604-453-8321