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

**PHYSICIAN REFERRAL FORM for**
**Early Motor Assessment / CP Early Diagnosis Clinic**

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

**Date of Referral:** _____

CHILD'S NAME: _____

Birthdate: (day/ month/ year):_____ Gender:_____ PHN:_____

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: (_____)_____

Email Address:_____

Child lives with: Mother_____ Father_____ Foster Family_____

Legal Guardian Name(s):_____ Phone: (_____)_____

Legal Guardian Address:_____

City:_____ Postal code:_____ Language:_____ Interpreter required? ☐ Yes ☐ No

## Please identify the clinic you are requesting:

☐ **Early Motor Assessment Clinic** serves infants with risk factors that may affect their motor development. Our occupational therapist conducts initial motor assessment, GMA (& HINE if needed), which determines if a more thorough assessment is needed. We take patient who is < 4 mo corrected age and does NOT have GMA done. See Section B: Early Motor Assessment Clinic Intake Criteria for details.

**Referral to the Early Motor Assessment Clinic, the following sections MUST BE FILLED.**
1. Section A: Referring physician, family physician and pediatrician Information, **AND**
2. Section B: Early Motor Assessment Clinic Intake Criteria

☐ **CP Early Diagnosis Clinic** serves infants with high-risk of CP. The team conducts examinations for CP early diagnosis. This clinic takes patient who is < 1 year old and has an abnormal GMA result. See Section C: CP Early Diagnosis Clinic Intake Criteria for details.

**Referral to the Cerebral Palsy (CP) Early Diagnosis Clinic, the following sections MUST BE FILLED.**
1. Section A: Referring physician, family physician and pediatrician Information, **AND**
2. Section C: CP Early Diagnosis Clinic Intake Criteria

## Section A: Referring physician, family physician and pediatrician Information

REFERRING PHYSICIAN: (Print Name)_____

Department / Clinic Name: _____ PHYSICIAN SIGNATURE: _____

Address:_____ (city)_____ (postal code)_____

Office telephone (_____)_____ Fax number: (_____)_____

Name of Family Physician: _____

Pediatrician: _____

## Section B: Early Motor Assessment Clinic Intake Criteria (Patient must meet ALL three criteria below)

Gestational Age (Mandatory Field): _____ weeks + _____ days

1. ☐ Patient is younger than 4 months corrected age, **AND**
2. ☐ Patient has NOT completed General Movements Assessment (GMA), **AND**
3. ☐ Patient has at least one of the following risk factors (please specify)
   - ☐ History of Stroke (Please specify age: _____)
   - ☐ Moderate / severe HIE
   - ☐ Meningitis (Please specify age:_____)

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## Section C: CP Early Diagnosis Clinic Intake Criteria (Patient must meet ALL three criteria below)

1. ☐ Patient is younger than 1 year old, **AND**
2. ☐ Patient has an abnormal General Movement Assessment (GMA) result, **AND**
3. ☐ Patient demonstrates at least one of the risk factors in Table 1 OR Table 2 (check all that apply)

| Table 1. Accepted Clinical / Developmental Risk Factors for CP | |
|---|---|
| ☐ | Child demonstrates a hand preference before 12mo of age |
| ☐ | Child is not able to sit without support beyond 9mo of age |
| ☐ | Child demonstrates stiffness or tightness in the legs |
| ☐ | Child keeps their hands fisted (closed/clenched) after the age of 4mo |
| ☐ | Child demonstrates a persistent head lag beyond 4mo of age |
| ☐ | Child demonstrates consistent asymmetryof posture and movement after the age of4mo |
| ☐ | Child demonstrates persistent primitive reflexes, including: startle (Moro) reflex beyond 6mo of age, or "Fencer" (ATNR) beyond 4mo of age |
| ☐ | Child demonstrates consistent toe-walking or asymmetric-walking beyond 12mo of age |

| Table 2. Accepted Medical Risk Factors for CP | |
|---|---|
| ☐ | Prematurity - < 32 weeks |
| ☐ | Very Low birth weight - <1500 g |
| ☐ | Cystic Periventricular Leukomalacia (PVL) |
| ☐ | Intraventricular Hemorrhage (IVH) Grade III-IV |
| ☐ | Moderate to severe neonatal Encephalopathy (including, but not restricted to: HIE, infectious encephalopathy) |
| ☐ | Neonatal meningitis |
| ☐ | Congenital CNS defects |
| ☐ | Severe traumatic brain injury requiring hospitalization or rehab, or any history of hospitalization due to encephalitis or bacterialmeningitis, before the age of two years |
| ☐ | Postnatal meningitis |
| ☐ | Genetic abnormality associated with CP |
| ☐ | Placental abruption |
| ☐ | Apgar <7 at age 5 minutes |
| ☐ | History of stroke |

**Infant's current and/or working diagnosis:**

Gestational Age (Mandatory Field): _____ weeks + _____ days

Birth Weight:_____ ☐ AGA ☐ SGA ☐ LGA

PLEASE ATTACH A COPY OF

1. ALL PERTINENT CONSULTS, REPORTS AND MEDICAL INVESTIGATIONS (i.e.: EEG, Labs – Metabolic, Genetics)
2. ALL GENERAL MOVEMENT ASSESSMENT (GMA) RESULTS ☐ Yes ☐ Available on Cerner/E-Chart
3. ALL NEONATAL FOLLOW-UP CLINIC REPORTS ☐ Yes ☐ N/A ☐ Available on Cerner/E-Chart
4. DISCHARGE SUMMARY FROM NICU ☐ Yes ☐ Available on Cerner/E-Chart
5. BRAIN IMAGING RESULTS (US/MRI) ☐ Yes ☐ Not Done ☐ Available on Cerner/E-Chart

Comment for reports / results: