SUNNY HILL HEALTH CENTRE
BC Children's Hospital
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PHYSICIAN REFERRAL FORM for NEUROMOTOR PHYSICIAN-TO-PHYSICIAN PHONE CONSULT SERVICE

Date of Referral: ________________

This referral form is specific to the **pilot neuromotor physician-to-physician phone/teleconference service** at Sunny Hill Health Centre. The purpose of this service is to provide community physicians with guidance and resources for making a diagnosis of cerebral palsy, and to assist with tone management. Referring physicians will be booked for a 20-minute phone or teleconference appointment with a neuromotor specialist. Please use the standard Sunny Hill Health Centre Neuromotor referral form for all other patient referrals.

REFERRING PHYSICIAN: (Print Name)____

PHYSICIAN SIGNATURE:______________________________ MSP #: ______________________________

Address:______________________________(city)____________________(postal code)______________

Office telephone: (____)______________________________Fax number: (____)______________________________

Email:____

Name of Family Physician: ____

Child's Current and/or Working Diagnosis:____

PLEASE ATTACH A COPY OF MOST RECENT REPORTS AND MEDICAL INVESTIGATIONS ☐ **Yes**

PLEASE INDICATE REASON / PURPOSE OF CONSULT

☐ **Support for diagnosing suspected cerebral palsy (CP) and/or questions relating to CP management**

☐ **Support for tone management**

☐ **Other (please describe ____)**

CHILD'S NAME:______________________________PHN: ______________________________

Birthdate: (day/ month/ year)______________________________Gender:______________________________

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:______________________________Interpreter required? ☐ Y ☐ N

Please select preferred time and method of communication for the appointment:

☐ Wednesdays between 11am - 1pm or ☐ Thursdays between 3pm - 5pm

☐ Phone (phone #:____) or

☐ Teleconference/Zoom (email: ____)

*Note: appointments will be scheduled for 20 minutes within the selected timeslot

Specific questions: