Complex Developmental Behavioural Conditions (CDBC)
and BC Autism Assessment Network (BCAAN)

Sunny Hill Health Centre
at BC Children's Hospital
4500 Oak St, Vancouver BC V6H 3N1
PH: 604-453-8320 FAX: 604-453-8321

PATIENT REFERRAL FORM (for children and youth up to their 19th birthday)

* For URGENT/EMERGENT Mental Health referrals, please refer to appropriate services(s)*

SUPPORTING DOCUMENTATION should include:

☐ Your consult letter outlining areas of significant concerns or difficulties

☐ Page 2 of referral concerns

☐ Other consultations (if available) from: ☐ IDP ☐ SLP ☐ OT/PT ☐ Psychology ☐ Other: _____

PATIENT INFORMATION (please print) REFERRAL DATE: _____

Child's name: *(Last)* _____ *(First)* _____ *(Middle)* _____

Date of birth *(yyyy/mm/dd):* _____ BC PHN#: _____ ☐ Male ☐ Female ☐ Other _____

Address where child lives: _____ *(City)* _____ *(PC)* _____

Phone numbers: *(Home)* _____ *(Work)* _____ *(Other)* _____

Child lives with: ☐ Mother ☐ Father

☐ Alternate/Foster Name: _____

Phone numbers: (*Home)* _____

(Work1) _____ *(Work2)* _____

(Cel 1) _____ *(Cel 2)* _____

(Other) _____

Legal Guardian's name *(& address if different from above)*

Name: _____

Address: _____

(City) _____ *(PC)* _____

☐ MCFD ☐ Other: _____

Day phone: _____ Other phone: _____

Interpreter needed? ☐ Yes ☐ No If yes, what language(s)?

PRIMARY REASON(S) FOR REFERRAL

☐ **Query Fetal Alcohol Spectrum Disorder** ☐ **Query Complex Developmental Concerns** ☐ **Query Autism Spectrum Disorder**

Is the LEGAL GUARDIAN aware of the primary reason for referral? ☐ Yes ☐ No Why not? _____

IN ADDITION TO DIAGNOSIS, ARE THERE QUESTIONS YOU OR THE FAMILY WOULD LIKE ANSWERED?

Is hearing a concern? ☐ Yes ☐ No If yes, has hearing test been ☐ Initiated ☐ Completed

Is vision a concern? ☐ Yes ☐ No If yes, has vision test been ☐ Initiated ☐ Completed

Known Medical Diagnoses (including genetic disorders, physical impairments, etc):

PHYSICIAN INFORMATION

Referring Physician's Name: *(Last)* _____ *(First)* _____ BC MSC # _____

☐ Pediatrician ☐ Family Practitioner ☐ Psychiatrist ☐ Other Medical Specialist: _____

Address: _____

Phone #s: _____ Fax #s: _____

Physician's Signature (mandatory) _____

Complex Developmental Behavioural Conditions (CDBC)
and BC Autism Assessment (BCAAN) Networks (March 2016)

The **CDBC Program** diagnostic assessment services are intended for children and youth who have significant difficulties in multiple areas of function including those with known or suspected history of exposures to substances with neurodevelopmental effects.

Referral from **pediatricians or child psychiatrists** is required (with exceptions based on access).

CDBC Referrals require a detailed consult. Please indicate if you have concerns about the following:

- ☐ **Development, Cognition, and Learning** – developmental history and current concerns
- ☐ **Adaptive and Social Skills** – self care, interpersonal skills, safety, etc.
- ☐ **Mental Health and Behaviour** – regulation, attention, mood, etc.
- ☐ **Bio Markers** – documented or substantiated evidence of exposure to environmental agents including alcohol. Dysmorphic features, suspected syndrome or observable abnormalities. Include face and growth measurements if available (FASD specific)

Additional Comments:

BCAAN provides diagnostic assessments for those with **suspected Autism Spectrum Disorder** and accepts referrals from **all physicians**.

Please indicate if you have concerns about the following:

☐ Mental Health/Behaviour ☐ Cognition/Developmental Delay ☐ Language

Please indicate your level of concern in each domain and provide examples of behaviours that support it:

Social Communication	**Repetitive Behaviours**
☐ Unknown/no concern	☐ Unknown/no concern
☐ Level 1 - noticeable impairments in social communication; difficulty initiating social interactions.	☐ Level 1 - noticeable inflexibility of behaviours cause significant interference with functioning.
☐ Level 2 - moderate deficits in verbal and nonverbal social communication; limited initiation of social interactions; reduced response to social overtures.	☐ Level 2 - moderate inflexibility of behavior; difficulty coping with change; obvious repetitive behaviours cause impairment in functioning.
☐ Level 3 - severe impairment in functioning; severe impairment in verbal and nonverbal social communication; difficulty initiating social connections; not responding to social overtures; inability to make friends; disconnected conversations.	☐ Level 3 - severe inflexibility or repetitive behaviours cause significant functional issues; difficulty changing focus; extreme difficulty coping with change.
Examples:	Examples:

Who is concerned about these behaviours? ☐ Guardian ☐ School ☐ Other professional (i.e. SLP, OT)_____

Attach copies of all documents that support this referral (i.e. school or daycare reports, speech and language reports, IDP reports).

Please mail or fax Referral Form (Page 1 and 2) and **send copies of all relevant consults, reports, and medical investigations to**: Triage Office, Sunny Hill Health Centre, 4500 Oak St, Vancouver, BC V6H 3N1
PH: 604-453-8320 FAX: 604-453-8321