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

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

Early Motor Screening Program

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

Early Motor Screening Program Intake Criteria (Patient must meet ALL four criteria below)

1. ☐ Patient is younger than 4 months corrected age, **AND**
2. ☐ Patient has NOT completed General Movements Assessment (GMA) during the fidgety phase, **AND**
3. ☐ Patient is NOT referred to do the fidgety phase GMA by other program (e.g. Neonatal Follow-up Program), **AND**
4. ☐ Patient demonstrates at least one of the risk factors below (check all that apply)

	Prematurity - < 32 weeks
	Very low birth weight - <1500 g
	Cystic Periventricular Leukomalacia (PVL)
	Intraventricular Hemorrhage (IVH) Grade III-IV
	Neonatal meningitis
	Congenital CNS defects
	Moderate to severe neonatal Encephalopathy (including, but not restricted to: HIE, infectious encephalopathy)

	Postnatal meningitis
	Genetic abnormality associated with CP
	Placental abruption
	Apgar <7 at age 5 minutes
	History of stroke
	Severe traumatic brain injury requiring hospitalization or rehab, or any history of hospitalization due to encephalitis or bacterial meningitis, before the age of two years

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

Infant's current and/or working diagnosis:

REFERRING PHYSICIAN: (Print Name)_____

Department / Clinic Name: _____PHYSICIAN SIGNATURE: _____

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

Office telephone (_____)_____Fax number: (_____)_____

Name of Family Physician (if known): _____

Pediatrician (if known): _____