

**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: 778-504-9768**

**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: 778-504-9768**