



**Allied Health Services & BDB 0-7 Clinic
Centralized Intake Referral Form**

1001, boul. Décarie, Suite A04-3140, Montréal, Québec, H4A 3J1
Telephone: (514) 412- 4496 Fax: (514) 412- 4136
Email: bdbci@muhc.mcgill.ca

Patient Information (please print) :

Date of birth (yyyy/mm/dd):		MCH File No.
Last name, First name		
Current address	City, Province	Postal Code
Phone number:	Other telephone number:	
Email	Language <input type="checkbox"/> French <input type="checkbox"/> English Other: _____ <input type="checkbox"/> Interpreter needed	

Referral date (yyyy/mm/dd):

Please specify the following: NB if child does not meet this criteria, please redirect the request to the family's residential sector CIUSSS / CISSS

Child resides within one of the following McGill RUISSS sectors: Nunavik, Outaouais, Cree Territory, West-Central Montreal and the West Island of Montreal, Nord du Québec, Montérégie West, Abitibi-Temiscamingue

OR

Actively followed by a tertiary service at the MCH (e.g. Oncology)

AND

Presents with developmental delays associated with a complex medical condition and/ or complex psychosocial situation (e.g. DYP case) Specify: _____

Previously followed by the NICU. Specify: _____

Please describe your concerns:

Please attach any additional information on a separate page.

Please select appropriate evaluations and specify reasoning:

NB for an Audiology assessment only, please use Audiology referral form available online on the MCH Website

ASD Assessment Parents have been informed of the suspicion of autism
 Significant social difficulties Communication limitations Unusual behaviour / play
 Other: _____

OR

Occupational Therapy Specify: _____

Clinical feeding evaluation regarding feeding safety and oral-motor skills by OT. Please indicate your safety concerns regarding feeding:

Needs a Videofluoroscopy: Yes (if yes, please send request directly to radiology 514-412-4347) No

Speech Language Pathology Specify: _____

Physiotherapy Specify: _____

OR

FASD Assessment Please specify the frequency, amount, duration and timing of prenatal alcohol exposure (PAE), signed or confirmed by the birth mother or other reliable source: _____

Please indicate if child is on the wait list or followed by these community services: Please specify name & coordinates

CRDP (Centre de réadaptation en déficience physique): _____
 CRDI-TSA (Centre de réadaptation en déficience intellectuelle et Trouble du spectre de l'autisme): _____
 CLSC / CISSS / CIUSSS (e.g. Agir Tôt): _____
 Youth Protection Services (e.g. DYP / Batshaw) Please provide coordinates of delegate(s): _____
 Other: _____

Previous assessments: Please include reports

Audio OT SLP Physiotherapy Psychology Psychiatry Other: _____

Referral Source:

Name of Referring Physician or Nurse Practitioner (please print):	License number:
Address:	
Telephone number:	Fax number:
Name of Treating Physician (if different):	
PARENTS ARE INFORMED AND AGREE TO THIS REFERRAL <input type="checkbox"/>	Signature: