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

PHYSICIAN REFERRAL FORM for NEUROMOTOR SERVICES

Phone: 604-875-2345
Toll Free: 1-888-300-3088
Fax: 778-504-9768

Date of Referral: _____

CHILD'S NAME: _____

Birthdate: (day/ month/ year)_____ Gender: _____

PHN: _____ ☐ Ambulatory ☐ Non-ambulatory 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: (_____)_____

Child lives with: Mother_____ Father_____ Foster Family_____

Legal Guardian Name(s):_____ Phone: (_____) _____

Legal Guardian Address:_____

City:_____ Postal code: _____ Language: _____ Interpreter required? ☐ Yes ☐ No

Child's Current and/or Working Diagnosis:

Please identify Team / Service you are requesting:

☐ Assistive Technology Team (ATT)
☐ Positioning and Mobility Team (PMT)
☐ Feeding Team
☐ Vision Team
☐ Hearing Team
☐ Tone Management (spasticity)
☐ Therapeutic Recreation: ☐ New Referral or ☐ Follow up from previous inpatient admission
☐ Aquatics: ☐ New Referral or ☐ Follow up from previous inpatient admission
☐ General Rehabilitation Clinic: ☐ New Referral or ☐ Follow up from previous inpatient admission

Specific referral questions:

PLEASE ATTACH A COPY OF ALL PERTINENT CONSULTS, REPORTS AND MEDICAL INVESTIGATIONS
(ie: CT Scan, EEG, Labs – Chromosomes, Fragile X, Psychology Testing, Developmental Testing)
When referring to these services, the following additional information (if available) is required:

☐ ATT Services: **Audiologist, vision, OT & SLP reports**
☐ Vision Services: **Ophthalmologist report**
☐ Feeding Services: **Growth charts & oromotor assessment**
☐ Hearing Services: **Audiologist report.**
☐ Positioning and Mobility and/or Tone services: **Orthopedic reports**

REFERRING PHYSICIAN: (Print Name)_____

PHYSICIAN SIGNATURE: _____

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

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

Name of Family Physician: _____

Pediatrician: _____