DEVELOPMENTAL HEALTH

❒ Corner Brook & North
Corner Brook Community Health Centre
1 Brookfield Avenue
Corner Brook, NL A2H 6J7
Phone: (709)784-5284
Fax: (709) 637-5155

❒ Stephenville & South
Rehabilitation Annex
127 Montana Drive
Stephenville, NL A2N 2T4
Phone: (709) 643-8690
Fax: (709) 643-3944

PRESCHOOL REFERRAL FORM

This referral will be received through a central intake process and it will be determined which services will be required for further assessment and intervention based on the information provided.

Check here to confirm client's caregiver(s) has been informed of this referral ❒

NAME: ______________________________ (First) (Middle) (Last)

GENDER: ______________________________

ADDRESS: ______________________________

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DOB: ______/______/______ (YYYY MM DD)

PHONE: ______________________________

MCP: ______________________________

E-MAIL: ______________________________

NOK: ______________________________

RELATIONSHIP: ______________________________

❒ Hearing
- ❒ Ear infections
- ❒ Ototoxic medications
- ❒ Hearing difficulty suspected
- ❒ Other ______________________

❒ Cognitive
- ❒ Delayed developmental milestones
- ❒ Decreased attention to task or hyperactivity
- ❒ Early risk factors
- ❒ Other ______________________

❒ Social/Interpersonal
- ❒ Play skills
- ❒ Difficulty with peer interactions
- ❒ Behaviour
- ❒ Other ____________________

❒ Self-Help
- ❒ Feeding/eating
- ❒ Toileting
- ❒ Dressing
- ❒ Other ______________________

❒ Physical
- ❒ Delayed developmental motor milestones
- ❒ Abnormal muscle tone
- ❒ Fine motor
- ❒ Balance/Coordination
- ❒ Other ______________________

❒ Communication
- ❒ Decreased vocabulary/sentence length
- ❒ Trouble pronouncing sounds
- ❒ Difficulty following directions
- ❒ Stuttering
- ❒ Other ______________________

❒ Sensory Processing/Self-Regulation

Is this referral being made to query a diagnosis of Autism Spectrum Disorder (ASD)? ❒ Yes ❒ No

Has a referral already been made to Janeway Outreach Services (Physiotherapy/Occupational Therapy)? ❒ Yes ❒ No

History/Comments:

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Referral Source: ______________________________ Phone: ______________________

Address: ______________________________ Date of Referral: ______________________

For office use only ❒ **Eligible** ❒ **Not Eligible**

Developmental Health ONLY

Referral to: ______________________ Comments: ______________________________

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Referral Source: ______________________________ Date: ______________________