Children's Treatment Network
Réseau de traitement des enfants

Request for Specialty Services Only

FAX to CTN ACCESS Intake at (705) 792-2775

Date of Referral: _____(dd-mmm-yyyy) CTN Shared Client ID Record Number: _____

CLIENT INFORMATION

Name: _____ DOB _____ Gender: M ☐ F ☐ O ☐
(Surname) (First) (dd-mmm-yyyy)

Address:

Health Card Number: Version Code: Expiry:

School: _____ Grade: _____
School Board: ☐ N/A ☐ YCDSB ☐ YRDSB ☐ SCDSB ☐ SMCDSB ☐ CSDCCS ☐ CSViamonde ☐ Other _____

Diagnosis: Physician: GMFCS:

CAREGIVER #1 Address Same As Client ☐ YES ☐ NO (complete fields)	**CAREGIVER #2** Address Same As Client ☐ YES ☐ NO (complete fields)
Relationship to Client: Custody:	Relationship to Client: Custody:
Name:	Name:
Address:	Address:
Primary #: Alternate #:	Primary #: Alternate #:
Email:	Email:
Language(s) Spoken: Interpreter: YES ☐ NO ☐	Language(s) Spoken: Interpreter: YES ☐ NO ☐
French Language Services Required? YES ☐ NO ☐	French Language Services Required? YES ☐ NO ☐

LOCAL TEAM ASSESSMENTS ARE REQUIRED PRIOR TO MAKING A REFERRAL TO A SPECIALTY ASSESSMENT AND CONSULTATION SERVICE.

SERVICE	REQUIREMENTS	
☐ Augmentative and Alternative Communication (ACCS)	Referrals only by SLP Guided Assessment for Daily Communication Partners Guided Assessment for Professionals (minimum last two pages)	☐ Attached ☐ Scanned to ECR
☐ Developmental Assessment and Consultation Services (DACS)	**Simcoe:** Physician Referral Form **York:** Physician Referral Form plus DACS Package	☐ Attached ☐ Scanned to ECR
☐ Seating and Mobility (SEAT)	Referrals only by an OT or PT Relevant Reports OR Seating Request Summary	☐ Attached ☐ Scanned to ECR
☐ Joint Management Botox©/Baclofan	Referrals only by an OT or PT plus Physician Relevant reports and/or supporting documentation	☐ Attached ☐ Scanned to ECR
☐ Psychological Assessment	Referrals only by School Psychologists or Developmental Paediatrician Relevant reports and/or supporting documentation **Referral MUST BE pre-approved by Dr. Jennifer Saltzman-Benaiah** **Pre-Approval Obtained/Confirmed by referrer on:**_____	☐ Attached ☐ Scanned to ECR
☐ CTN Medical Consult	Referrals by Physicians only	

Youth/Family agree with this Referral including the collection and sharing of information for the purposes of processing Referral. ☐ YES ☐ NO

The CTN Network Consent for Sharing of Information among Child & Family Team members has been discussed/completed with the Youth/Family ☐ YES ☐ NO
If YES, please attach consent form Who has provided the consent? . ☐ Client/Youth ☐ Parent/Guardian ☐ CAS

Youth/Family agree to CTN's use of email for purpose of communicating with the family about upcoming Network events & Educational opportunities ☐ YES ☐ NO

_____ _____ _____
Signature of Referring Person *Print name and Professional Designation* *Date (dd-mmm-yyyy)*

_____ _____ _____
Name of Referring Agency *Email Address* *Referrer's Telephone*

FORM REVISED: March-27-2018