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	
☐ 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*

This FAX and all attachments contain confidential and privileged information. If you are not the intended recipient, please notify the sender immediately by return Fax or by phone to the above number and destroy this FAX and any copies.

FORM REVISED: **September 12-2019**