

The CHEO Access Team is the central intake to Children's Treatment Centre services, physiotherapy, occupational therapy, speech language pathology and First Words.



CHEO Access Team, Delivering SmartStart Hub services.

Date form completed:		
Please complete all sections to the best of your know	vledge.	
Family is aware of the referral and agrees: Yes		
Parent/Guardian consent is mandatory for CHEO to process t	his referral.	
CHILD INFORMATION:		
Child name:		
Last Name	First Name	Middle Name(s)
Date of Birth:	Male Female	Self-Identify:
Day/Month/Year		_
Health Card Number:	Version Code:	Health Card in Process
Language of Service: English French		at language:
Street name and number City	Province	Postal Code
Primary Parent/Guardian Name:	Telephone Number:	
Relationship to child:	Email:	
Secondary Parent/Guardian Name:	Telephone	e Number:
Reason for Referral (please check all that appl	<u>y):</u>	
Concerns about Speech/Language Delay	Child has I	peen diagnosed with:
Concerns about Fine and/or Gross Motor Delay		
Concerns about signs of Autism	(Please inc	clude diagnostic report with referral form).
Concerns about overall development	Physical D	isability (please specify):
Concerns about possible FASD (Fetal Alcohol Syndrome Disorder) Other:	(Please inc	clude diagnostic report with referral form).

Describe in your own words any concerns/goals that you have:		
	Relationship to child:ng, please provide billing number and clinic fax/address.	
	ral. A member of our team will inform you if one is needed after submission of this form.	
If you have a question about this form, please contact 613.737.2757or 1.800.565.4839		