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

Date form completed:

_____

Please complete all sections to the best of your knowledge.

Family is aware of the referral and agrees: ☐ Yes

Parent/Guardian consent is **mandatory** for CHEO to process this 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

Language(s) spoken at home: _____

Interpreter required? If yes, what language: _____

Address: _____
Street name and number City Province Postal Code

Primary Parent/Guardian Name: _____ Telephone Number: _____

Relationship to child: _____ Email: _____

Secondary Parent/Guardian Name: _____ Telephone Number: _____

Reason for Referral (please check all that apply):

☐ Concerns about Speech/Language Delay
☐ Concerns about Fine and/or Gross Motor Delay
☐ Concerns about signs of Autism
☐ Concerns about overall development
☐ Concerns about possible FASD (Fetal Alcohol Syndrome Disorder)
☐ Other:

☐ Child has been diagnosed with:

_____

(Please include diagnostic report with referral form).

☐ Physical Disability (please specify):

_____

(Please include diagnostic report with referral form).

*Please fax completed form to 613.738.4841 or by mail to **CHEO Access Team**, 395 Smyth Rd, Ottawa, ON K1H 8L1*

Describe in your own words any concerns/goals that you have:

Name of referral source: _____ Relationship to child:_____

If Physician referring, please provide billing number and clinic fax/address.

N. B. some services require a medical referral. 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

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