John McGivney CHILDREN'S CENTRE

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REFERRAL FORM

The John McGivney Children's Centre provides rehabilitative services to the Essex County community, enriching the lives of children and youth with disabilities and special needs by helping them reach their full potential.

Client Name: _____ _____ ☐ M ☐ F
Last Name First Name

DOB (day/month/yr): _____ Health Card #: _____

Parent/Guardian: _____

Home Address: _____ City: _____ Postal Code: _____

Telephone (home): _____ Telephone(■ work ■cell): _____

School: _____ Primary Care Physician: _____

Diagnosis: _____

Referral Objectives:

PLEASE NOTE:
The family physician will continue to have responsibility for ongoing general medical treatment. The Centre reserves the option of obtaining a comprehensive assessment or other appropriate consultation.

What are your areas of concern:

☐

Diagnostic Tests Completed/Pending:

☐ Blood Work	☐ X-rays
☐ Hearing	☐ MRI/CT Scan
☐ Vision	☐ EEG
☐ Genetics	☐ Psychology

Other Agencies Involved: ☐ Children First ☐ CAS ☐ NICU follow-up clinic ☐ Other _____

Current Medication: _____

Who is making this referral: _____ Relationship to Client: _____

Address: _____ Postal Code: _____

Telephone: _____ Date: _____

Form Completed by:

Other Relevant Information: