Service request -
Eastern Ontario Children Rehabilitation Program
Therapeutic services

Patient label

Letter of acknowledgment: ☐ Date sent :

** All sections must be completed for the request to be accepted.

Reference requested/filled in by : ☐ Health professional ☐ Parent

Parents must complete ALL sections of the form.
Healthcare professionals MUST complete Section 1 only.

Name :	Profession:
Clinic address :	
Phone number :	

☐ The parent(s) or legal guardian(s) have been informed of the eligibility criteria for the Children's Rehabilitation Program with respect to the child's age.

1. CHILD CONCERNED BY THE REQUEST

First name :	Last name :		
DOB (d/m/y) :	Age :	Sex: Boy ☐ Girl ☐	
Address:	City :	Province :	Postal code :
Health card number (OHIP, RAMQ or other - including version code for Ontario):		Expiry date :	
Service language: ☐ French ☐ English	☐ Boy ☐ Girl	Family doctor :	
☐ **Known diagnosis (indicate diagnosis) :**		☐ **No diagnosis**	

Confirm that the parent or legal guardian has been informed of the reasons for the request for services and consents to it. ☐

***PLEASE NOTE: The following difficulties will not be treated: behavioral problems, oppositional diagnosis. Children in specialized classes (ASD, language) are only eligible for the following speech therapy services: articulation/phonology, stuttering and voice.

Reason for referral. Please check the concerns you have for your child:

☐ Little vocabulary	☐ Gross motor skills	☐ Fine motor skills
☐ Does not produce complete phrases	☐ Coordination	☐ Pencil/scissors grip
☐ Does not understand instructions	☐ Torticollis	☐ Sensory responses
☐ Does not understand the questions well	☐ Plagiocephaly	☐ Playing skills
	☐ Difficulty sitting up alone	☐ Social skills
☐ Does not talk	☐ Difficulty walking	☐ Power supply
☐ Does not articulate/pronounce well well certain sounds	☐ Difficulty jumping	☐ Dressing skills
	☐ Difficulty riding a bike	☐ Potty training
☐ Stutter	☐ Poor muscle tone/strength	☐ Sleep
☐ Difficulty reading and writing	☐ Hypnotonia/Hypertonia	☐ School preparation
		☐ Writing

Other / Comments :

2. IDENTIFICATION OF PARENTS OR LEGAL GUARDIAN

Who does the child live with?

☐ Both parents ☐ Father ☐ Mother

☐ Shared custody **If the parents are divorced/separated, who has custody?**
☐ Father ☐ Mother

☐ A host family	Since when?	For how long?
☐ An adoptive family	Since when?	Country of Origin :

Parent's name :

Name of legal guardian :

E-mail address :	Occupation:
Telephone (home) :	Usual language :
Phone (cell) :	Telephone (work) :

Nº 1: Address (if different from above):

Parent's name :

Name of legal guardian :

E-mail address :	Occupation:
Telephone (home) :	Usual language :
Telephone (cellular) :	Telephone (work) :

Nº 2: Address (if different from above) :

3. ASSESSMENT AND PREVIOUS INTERVENTIONS

Professionals consulted	Year	Reviews	Intervention	Reports available
Audiology				
EOHU				
Youth Center (DPJ)				
CLSC				
Occupational therapy				
Social worker				
Neurology				
Speech Therapist				
Orthopedics				
Speech Therapy				
Pediatrician				
Child psychiatrist				
Physiotherapist				
Psychoeducator				
Psychology				
Valoris				
Applied Behavior Analysis (ABA)				
Services not mentioned and/or comments :				

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***Please send us any documents you have on hand (previous evaluations, authorization to disclose information, recommendations, medical reports, progress reports, intervention plans, etc.).**

*****The request will not be accepted without all the required documentation.****

*** Send the documents by mail to the following address:**

Eastern Ontario Children Rehabilitation Program
Hawkesbury and District General Hospital
1111, Ghislain St., Hawkesbury (Ontario) K6A 3G5

OR

By fax: 613-636-6160
By email: TherapeuticServices@hgh.ca