ST. JOSEPH'S
UNITY HEALTH TORONTO

CHILD DEVELOPMENT CLINIC REFERRAL FORM

DR FLANAGAN DEVELOPMENTAL PAEDIATRICIAN
30 The Queensway, Toronto, ON M6R 1B5
Garron Family - Our Lady of Mercy Wing, 3rd Floor
Tel: 416-530-6000 x4449 Fax: 416-530-6294
Email: cdevclinic@stjoestoronto.ca

DATE OF REFERRAL:_____

PATIENT INFORMATION	REFERRING PROVIDER INFORMATION
Last Name: _____ First Name: _____ Preferred Name: _____ Date of Birth: _____ (DD/MM/YEAR) ☐ Female ☐ Male Health Insurance: ☐ HCN: _____ ☐ IFH: _____ ☐ Private Insurance: _____ ☐ None: Phone Number: _____ Address: _____ Postal Code: _____	**Please select one of the following:** ☐ Family Physician ☐ Paediatrician ☐ Nurse Practitioner ☐ Other First Name: _____ Last Name: _____ Contact Number: _____ Fax Number: _____ Signature: _____ Billing Number: _____ **Are you this patient's primary care provider?** ☐ Yes ☐ No **If not, please provide name and contact information?** Name: _____ Phone Number: _____ Fax Number: _____

PARENT/GUARDIAN INFORMATION

By listing telephone numbers or an e-mail address below, the referral source confirms that the patient/parent consents for Unity Health to call or e-mail them regarding this referral. Unity Health will refrain from communicating unrequired personal information until consent is verified.

Primary Guardian's First Name: _____ **Last Name:** _____
***Email (required):** _____ **Phone Number:** _____
Relationship to Patient: _____
Address same as patient
Different address: _____

Secondary Guardian's First Name: _____**Last Name:** _____
***Email (required):** _____ **Phone Number:** _____
Relationship to Patient: _____
Address same as patient
Different address: _____

Language: _____ Interpreter Required: ☐ Yes ☐ No

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REFERRAL CRITERIA	REQUIRED INFORMATION
● **Age less than or equal to 3 years 11 months** ● **St. Joseph's Health Centre catchment area:** M5N, M5P, M5R, M5S, M5T, M5V, M6C, M6E, M6G, M6H, M6J, M6K, M6N, M6P, M6R, M6S, M6V, M7A, M8V, M8W, M8X, M8Y, M8Z, M9A, M9B, M9C ● **Delays in 2 or more areas:** □ Speech and language skills □ Play skills □ Fine motor skills □ Gross motor skills □ Social skills □ Behaviour □ Adaptive living skills (toileting, feeding) □ Cognitive	● Speech and language assessment reports ● SLP name: _____ ● Blood work results (genetic, metabolic) ● Audiogram within 3 months of referral (please book if not done) ● Other referrals ● For your primary care patient, please include the Nipissing, MCHAT, head circumference and growth charts ● For a consult patient, please include consult note, relevant results and investigations

***PLEASE SEND ALL SUPPORTING DOCUMENTS AT TIME OF REFERRAL.**
***REFERRALS WITH THE REQUIRED DOCUMENTAION WILL BE GIVEN PRIORITY.**

REASON FOR REFERRAL
Please indicate the primary reason for referral (specify current symptoms, presenting problems and relevant history).

Thank you for your referral to St Joseph's Health Centre Paediatrics. Please note failure to include the requisite charts/reports may result in delays in booking. It is also important to note that we are ***not a crisis or emergency service***. Should your patient be in need of urgent support, please direct them to the nearest emergency department or call 911.

INCOMPLETE REFERRALS WILL BE RETURNED FOR COMPLETION
Fax completed referral form to (416) 530-6294
We will notify the patient of their appointment date and time