# REFERRAL FORM

DEVELOPINGHANDS PEDIATRIC THERAPY

## CHILD & FAMILY INFORMATION

Child's Name:

_____

*First* *Last*

Parent/ Guardian's Name:

_____

*First* *Last*

Phone: _____ Email **:** _____

### MY CHILD NEEDS ASSISTANCE IN THE FOLLOWING AREAS:

## OCCUPATIONAL THERAPY

| | | | |
|---|---|---|---|
| ☐ **Fine Motor Skills** | ☐ **Gross Motor Skills** | ☐ **Self-Care Skills** | ☐ **Sensory Needs** |
| ☐ Eye-Hand Coordination | ☐ Mobility, Walking, Running | ☐ Dressing (Zippers, Buttons, Laces) | ☐ Self-Regulation |
| ☐ Pencil Grasp & Control | ☐ Upper Body Strength | ☐ Brushing Teeth, Hair | ☐ Sensitivity to Smell, Sound or Light |
| ☐ Printing/Cursive Writing | ☐ Body Awareness | ☐ Feeding/Use of Cutlery | ☐ Sensitivity to Touch and/or Textures (Cloth-ing/Food) |
| ☐ Sentence Composition | ☐ Coordination/Balance | ☐ Toileting | ☐ Mouthing, Chewing Ob-jects |
| ☐ Scissors Use | ☐ Muscle Tone | ☐ Planning & Sequencing | |
| ☐ Typing | ☐ Riding a Trike or Bike | | |
| ☐ **Visual Perception** | ☐ **Equipment Prescription** | ☐ **Attention/ Focus** | ☐ **Diagnoses** |
| ☐ Spatial Awareness | ☐ Assistive | ☐ Completing Tasks | ☐ Learning Disabilities |
| ☐ Reversing Letter | ☐ Technology | ☐ Fidgeting | ☐ Developmental Delay |

☐ Sorting & Organizing ☐ Down Syndrome ☐ Autism Spectrum Disorder

☐ Cerebral Palsy ☐ Other

## SPEECH & FEEDING THERAPY

☐ **Articulation**

☐ Clarity of Speech

☐ Lisps

☐ Execute Speech

☐ **Language Development**

☐ Late Talker

☐ Low Word Count

☐ Sentence Composition

☐ **Fluency**

☐ Stuttering

☐ Speed, Flow, Rhythm of Speech

☐ Slurring/ Mumbling

☐ **Motor Speech**

☐ Apraxia

☐ Plan, Control, Coordinate

☐ **Diagnoses**

☐ Delayed Intellectual Development

☐ Down Syndrome

☐ Autism Spectrum Disorder

☐ Cleft Lip and Palate

☐ Cerebral Palsy

☐ Hearing Impairment

☐ Selective Mutism

☐ **Orofacial Myofunctional Disorders (OMD)**

☐ Breast feeding Issues

☐ Facial Skeletal Growth and Development

☐ Oral Hygiene

☐ Temporomandibular Joint Dysfunction

☐ **Oral** Breathing

☐ **PROMPT Therapy**

☐ **Feeding**

☐ Picky Eater

☐ Refusing to Eat

☐ Gagging/Chocking while eating

☐ Difficulty Chewing/ Swallowing

☐ Fear of Eating

☐ Sensitivity to Food Textures

## PHYSIOTHERAPY

☐ **Gross Motor Skills**

☐ Balance/Coordination

☐ Muscle Tone

☐ Gait (Walking Pattern)

☐ In-Toe Walking

☐ **Muscle Tightness**

☐ Torticollis

☐ Toe Walking

☐ Hip Tightness

☐ **Developmental Milestones**

☐ Tummy Time

☐ Crawling

☐ Walking

☐ Standing

☐ **Premature Baby**

☐ Muscle Strengthening

☐ Range of Motion

☐ Developmental Milestones

☐ Strength & Tone
☐ Rolling
☐ **Lo**wer Body Strength
☐ Sitting
☐ Posture

☐ **Congenital Anomalies**
☐ **Post-Operative Rehab**
☐ **Motor Vehicle Accident (MVA) Rehab**
☐ **Sport Injury Rehab**
☐ Congenital Heart Defect

## OSTEOPATHY

☐ Developmental Milestone
☐ Sleep Issues
☐ Digestive Problems
☐ Difficulty Swallowing
☐ Mobility
☐ Constipation
☐ Muscle Joint Pain
☐ Sports Injury
☐ Breastfeeding/Nursing
☐ Latching Issus
☐ Plagiocephaly (flat head)
☐ Headaches
☐ Colic
☐ Gagging/Chocking/Reflux
☐ Irritability

## COUNSELLING (CLINICAL SOCIAL WORKER)

☐ Abuse
☐ Anxiety
☐ Grief
☐ Family Changes (Separation/Divorce)
☐ Family Violence
☐ Depression
☐ Self-Harm
☐ Other
☐ Self Esteem
☐ Bullying

## PSYCHOLOGICAL ASSESSMENTS

☐ Psychoeducational Assessment
☐ Gifted Assessment

Additional Concerns/Comments: _____

_____

_____

_____

_____

Developing Hands Pediatric Therapy
22-3100 Ridgeway Dive, Mississauga, ON
11-1235 Queensway East, Mississauga, ON

DevelopingHands.com
inquiries@developinghands.com

Phone: 416-576-6842
Fax: 1-888-371-9342

| | In-Clinic (22-3100 Ridgeway Drive, Mississauga) | In-Home* | Online | Other* |
|---|---|---|---|---|
| Desired Service Location: | ☐ | ☐ | ☐ | ☐ |

* Address: _____

| Availability for Services: | MON | TUE | WED | THU | FRI | SAT | SUN |
|---|---|---|---|---|---|---|---|
| MORNING | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| AFTERNOON | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| EVENING | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

## Referral Methods

1. ECE/ Teacher can **fax** or **email** this form to Developing Hands on behalf of the child/ student (with parental consent).
2. ECE/ Teacher can **hand this form to the child's parent/ guardian** and parent/ guardian can call Developing Hands directly.

ECE/ Teacher's Name: _____ _____

*First* *Last* *Date*

DEVELOPINGHANDS
PEDIATRIC THERAPY

**To Book Call**
416-576-6842

**Clinic Address**
22-3100 Ridgeway Drive
11-1235 Queensway East
(Mississauga)

**FAX**
1-888-371-9342

To **Book an Appointment**, Call or Email

**To Book Email:**
inquiries@DevelopingHands.com

**Visit Us at:**
https://DevelopingHands.com

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