



NEURODEVELOPMENTAL SERVICES REFERRAL FORM

Referral form for the Child Development Clinic and the Manitoba FASD Centre.

Please send original by mail or fax copy to:

Neurodevelopmental Services Intake
Rehabilitation Centre for Children, SSCY Centre
1155 Notre Dame Avenue, Winnipeg, MB R3E 3G1
Phone: 204-258-6621 Fax: 204-258-6798

Please note: All referrals are screened for eligibility.

REFERRAL DATE: ____/____/____
m/d/y

Child/Youth Name: _____ Last Name First Name Middle Name	Date of Birth: ____/____/____ m/d/y	
MHSC #: _____	PHIN #: _____	Gender: _____
Address: _____	City/Town: _____	Postal Code: _____
Home Phone: (____) _____	Cell: (____) _____	
Caregiver Name: _____	Relationship to Child/Youth: _____ <i>(birth, adoptive, foster, other.)</i>	
Address: _____ <i>(If different than above)</i>	City/Town: _____	Postal Code: _____
Home Phone: (____) _____	Cell: (____) _____	Email: _____
Caregiver Name: _____	Relationship to Child/Youth: _____ <i>(birth, adoptive, foster, other.)</i>	
Address: _____ <i>(If different than above)</i>	City/Town: _____	Postal Code: _____
Home Phone: (____) _____	Cell: (____) _____	Email: _____

If the child/youth is in the care of a child welfare agency, please complete:

Name of worker: _____	Agency: _____
Phone: (____) _____	Fax: (____) _____
Child/Youth Status:	Email: _____
Permanent ward <input type="checkbox"/> Temporary ward <input type="checkbox"/> Voluntary Placement Agreement <input type="checkbox"/> Other <input type="checkbox"/> _____	

Child/Youth's Name: _____

DOB: _____

Other Diagnoses/Medical History: **Attach Medical Specialist reports (e.g., genetics, neurology, etc.)*

Current Medications:

Does this child/youth attend school: Yes No

Does this child attend childcare/pre-school program: Yes No

Has the child/youth had an assessment in the past or is currently accessing services (e.g., Speech-Language Pathology, Occupational Therapy, Physiotherapy, Audiology, Psychology)?

Yes No **If yes, please attach available reports.*

If needed, please initiate referrals to Allied Health Services for children/youth who present with concerns in the areas of speech development, gross motor delays, fine motor delays, and/or behavioral challenges.

Referral form is available at Children's Therapy Network of Manitoba (CTNM), ph: 204-258-6550

<https://www.gov.mb.ca/fs/ctnm/pubs/ctnm-referral-form-churchill-wpg.pdf>

<p><u>For Referrals to:</u> Child Development Clinic 0 to 5 years (prior to Kindergarten entry) Complete ONLY PART A (pg.3) Physician/Nurse Practitioner referral required</p>	<p><u>For Referrals to:</u> Manitoba FASD Centre 0 to 17 years Complete ONLY PART B (pg.4) Physician/Nurse Practitioner referral recommended.</p>
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Child/Youth's Name: _____

DOB: _____

PART A: COMPLETE FOR REFERRAL TO THE CHILD DEVELOPMENT CLINIC
(0 to 5 years – prior to Kindergarten entry)

Please submit additional pages if more space is needed.

This clinic provides developmental assessments for children 5 years of age and younger. Criteria for an assessment is ongoing concerns in several areas of development.

Please check current concerns (check all that apply):

- Complex Developmental Delays in 2 or more areas - motor, language and cognitive
- Complex Behavior - regulation, attention, mood, activity level, etc.
- Complex Motor Delays – including possible Cerebral Palsy
- Suspected Autism Spectrum Disorder

Please provide details (e.g., developmental history, observations, previous and current interventions):

REFERRING PHYSICIAN / NURSE PRACTITIONER: *Required for all referrals to the Child Development Clinic

Name and designation (*Please print clearly*): _____

Name of Office: _____

Address: _____ Postal Code: _____

Phone: (____) _____ Fax: (____) _____

Signature: _____

Child/Youth's Name: _____

DOB: _____

PART B: COMPLETE FOR REFERRAL TO THE MANITOBA FASD CENTRE (0 to 17 years)

Please submit additional pages if more space is needed.

Referral Criteria Includes:

Confirmed significant alcohol exposure during pregnancy. *Please provide details:*

For consultation on gathering prenatal alcohol exposure, please contact a social worker at the MB FASD Centre at 204-258-6600.

AND concerns with:

Development, Cognition and/or Learning. *Please provide details:*

Complex Behavior - regulation, attention, mood, activity level, etc. *Please provide details:*

If concerns include possible ADHD and/or mental health concerns, please proceed with appropriate assessment, management and/or community referrals (e.g., pediatrician, Shared Health MH and Addictions (MATC), psychiatry).

REFERRING PHYSICIAN / NURSE PRACTITIONER: **Recommended*

Name and designation (*Please print clearly*): _____

Name of Office: _____

Address: _____ Postal Code: _____

Phone: (____) _____ Fax: (____) _____

Signature: _____

OTHER REFERRAL SOURCE: **If not Physician/Nurse Practitioner*

Name: _____ Relationship to child/youth: _____

Address: _____ Postal Code: _____

Phone: (____) _____ Email: _____

Signature: _____ Name of child/youth's Physician: _____

If applicable, name of person assisting with the completion of this form: _____

For referrals received from other sources, an FASD team member will contact the family to discuss their concerns and will include communication with the child/youth's primary health care provider.