MARKHAM STOUFFVILLE HOSPITAL
Childrens Treatment Network
13175 Yonge Street
Oak Ridges ON L4E 0G6

Developmental Assessment and Consultation Services
Phone: (905) 954-4011 Fax: (905) 773-7090

REFERRAL

Child's Name:		Date of Birth: *(day, mon., yr.)*	Sex:
Date of Referral:	Referred by(Service and Name):	HC #	
Parent(s)/Guardian:			
Address:		Home Phone: ( )	
Postal Code		Work Phone: ( )	

Reason for Referral:

- ☐ Global Developmental Delay
- ☐ Autism Spectrum Disorder
- ☐ Speech/Language Delays
- ☐ Visual/Perceptual Difficulties
- ☐ Social Delays
- ☐ Fine/Gross Motor Delays
- ☐ Cognitive Delays
- ☐ Behaviour

Psychosocial Issues:

Other assessments/investigations and results: *(by whom and date)*	Developmental:	
Hearing:	Speech:	
Vision:	OT:	PT:
Genetics:	Psych:	

What observations have led to this referral?

Have your concerns/questions been discussed with the family? ☐ Yes ☐ No

Summary of current assessment: (eg. HELP, Speech) ***(please attach all reports)***

Is this child receiving services elsewhere? (ie. CAS, school, CCAC, EIS)

☐ No ☐ Yes - where? _____

Please add any additional information that will be of assistance to us.