MARKHAM STOUFFVILLE HOSPITAL CORPORATION

Childrens Treatment Network
13175 Yonge Street
Oak Ridges, ON L4E 0G6

DEVELOPMENTAL ASSESSMENT AND CONSULTATION SERVICES REFERRAL

Phone: (905) 954-4011 Fax: (905) 773-7090

Child's Name:	Date of Birth *(DD/MM/YYYY)*	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 ☐ Social Delays
☐ Speech/Language Delays ☐ Visual/Perceptual Difficulties ☐ Behaviour
☐ Fine/Gross Motor Delays ☐ Cognitive Delays

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.