Quinte Children's Treatment Centre
Preschool Speech and Language Program

Telephone: 613-969-7400 Ext. 2264 / Fax: *613-961-2529*
Quinte Health Care Belleville General Hospital, 265 Dundas Street East, Belleville K8N 5A9
www.quintectc.com

REFERRAL FORM

Referral Date: Day/Month/Year: _____

Child's Name: First: _____ Last: _____

D.O.B: Day/Month/Year: _____ Gender: _____

Health Card #: _____ Version Code_____ Expiry Date _____

Address: _____
(Street) (City) (Postal Code)

Contact Person: (*Parents/Legal Guardian*) _____
Surname *Given Name(s)* *Relationship*

_____(____)_____ (____)_____
Address (If different from above) *Home Phone #* *Work Phone #*

Family Doctor: _____

Other physicians/agencies involved_____

_____

Diagnosis: (if known) _____

Has diagnosis been discussed with parent? Yes____ No___

Please describe areas of concern /need for intervention and type of assessment/treatment being requested:

_____

_____

☐ Gross-Motor ☐ Fine-Motor ☐ Self-Care ☐ Speech and Language ☐ Overall development
☐ Medical (related to developmental or long term physical disability)

Referred by _____ Signature _____

Address _____ Phone number _____
***Please attach all recent relevant consultation reports or history.*

PLEASE NOTE: CHILDREN WHO ONLY REQUIRE SPEECH AND LANGUAGE CAN BE REFERRED BY OTHER AGENCIES WORKING WITH THE FAMILY. HOWEVER, PARENTS MUST SIGN BELOW GIVING CONSENT FOR THE REFERRAL. ALL OTHER REQUESTS REQUIRE A PHYSICIAN'S REFERRAL.

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Signature of Parent Date