

NB For URGENT/EMERGENT Mental Health referrals, please refer to appropriate service(s)

PATIENT REFERRAL FORM (for children and youth up to their 19th birthday)

The **CDBC Program** diagnostic assessment services are intended for children and youth who have significant difficulties in multiple areas of function including those with known or suspected history of exposures to substances with neurodevelopmental effects. Referral from pediatricians or child psychiatrists is required (with exceptions based on access). **BCAAN** provides diagnostic assessments for those with **suspected autism spectrum disorder** and accepts referrals from all physicians.

SUPPORTING DOCUMENTATION IS REQUIRED and should include:

- o Your consult letter outlining areas of significant concerns or difficulties
- o Page 2 checklist of referral concerns
- o Other consultations (if available) from: IDP SLP OT/PT Psychology Other

PATIENT INFORMATION (please print)

REFERRAL DATE:

Child's Name: (Last) _____ (First) _____ (Middle) _____

Date of Birth: (yyyy/mm/dd) _____ Male Female BC PHN#: _____ - _____ - _____

Child Lives With: Mother Father Both Alternate/Foster Other _____

Address Where Child Lives: _____

City _____ PC _____ - _____

Legal Guardian's Name: (Last) _____ (First) _____ (Middle) _____

OR MCFD Other _____

Legal Guardian's Address (if different from above): _____

City _____ PC _____ - _____

Phone Numbers: (Home) _____ (Work) _____ (Other) _____

Need for an Interpreter? Yes No If Yes, what language/s? _____

Does THE LEGAL GUARDIAN AGREE WITH THIS REFERRAL? Yes No Why not? _____

PRIMARY REASONS FOR REFERRAL

- Query Fetal Alcohol Spectrum Disorder Query Complex Developmental Concerns Query Autism Spectrum Disorder

IN ADDITION TO DIAGNOSIS, ARE THERE QUESTIONS YOU/OR THE FAMILY WOULD LIKE ANSWERED?

Hearing testing has been: Initiated Completed Not a Concern Result _____

Vision testing has been: Initiated Completed Not a Concern Result _____

Known Medical Diagnoses (including genetic disorders, physical impairments, etc.):

PHYSICIAN INFORMATION

Referring Physician's Name: (Last) _____ (First) _____ BC MSC # _____

Are you a: Paediatrician Family Practitioner Psychiatrist Other Medical Specialist Other _____

Address _____

Phone #'s (_____) _____ Fax #'s (_____) _____

Physician's Signature (mandatory): _____

Complex Developmental Behavioural Conditions (CDBC) and BC Autism Assessment (BCAAN) Networks

PLEASE COMPLETE THE FOLLOWING CHECKLIST IDENTIFYING ALL AREAS OF CONCERN:

Developmental and Learning

Cognition (including Memory and Reasoning)	<input type="checkbox"/> Challenges in retaining new information; understanding abstract concepts or understanding cause/ effect relationships at the expected level for child's age <input type="checkbox"/> Evidence of significant difficulties as measured on a Standardized Developmental/Intelligence Quotient testing if available
Communication	<input type="checkbox"/> Difficulty with receptive language such as understanding class discussions or following spoken instructions <input type="checkbox"/> Difficulty with expressive language (expressing thoughts and feelings) or telling a story so that it can be understood and/ or severe difficulties with speech intelligibility and/or <input type="checkbox"/> Impairments in social communication (e.g. <i>language delay not compensated by gestures; cannot sustain conversation; repetitive/odd language</i>)
Academic & Pre-Academic Skills	<input type="checkbox"/> Difficulties in acquiring basic concepts (i.e. <i>reading, spelling, writing, math</i>) functioning at least one year below grade level in primary grades and two or more years below grade level in intermediate grades
Motor Skills	<input type="checkbox"/> Gross motor planning/ coordination (e.g. <i>severe difficulties acquiring new motor skills given age such as ball skills/ tricycle/ bicycle riding</i>) and/ or <input type="checkbox"/> fine motor control/ coordination difficulties (e.g. <i>marked difficulty accomplishing fine motor tasks expected for age such as manipulating fasteners on clothes, tying shoe laces, writing/ printing, etc.</i>)

Mental Health/ Behaviour

Attention and Activity Regulation	<input type="checkbox"/> Distractible, overly active, impulsive, needs constant supervision, difficulty remaining seated in classroom, interrupts or intrudes on others, impatient
Social Behaviour	<input type="checkbox"/> Defiant, hostile towards authority figures, aggression to people or animals, destruction of property, fire setting, sexually inappropriate, alcohol/ substance abuse <input type="checkbox"/> Intense stereotyped/restricted patterns interest, adherence to nonfunctional routines/rituals, stereotyped/repetitive motor mannerisms, preoccupation with parts of objects
Mood Stability	<input type="checkbox"/> Irritability/sadness, social withdrawal, rapid/ drastic mood changes, prolonged temper outbursts, anxiety

Adaptive and Social Skills

Social Skills And Peer Relations	<input type="checkbox"/> Limited eye contact/facial expressions; poor cooperative play with peers; difficulty making/keeping friends; diminished sharing (enjoyment/interests/achievement) with others; reduced social/emotional reciprocity
Self-Care	<input type="checkbox"/> Significant delays in dressing, toileting, eating, hygiene, health
Safety	<input type="checkbox"/> Child/youth has difficulty understanding physically dangerous situations, stranger awareness
Community Living (for over 6 only)	<input type="checkbox"/> Child/ youth has difficulty using a phone, understanding concepts of time and money, finding a public restroom, using public transportation

Biomarkers

Prenatal Exposure to Environmental Agents (i.e. alcohol and/ or other neuroteratogenic exposures)	<input type="checkbox"/> High Risk Exposure (e.g. <i>confirmed substantial, regular or heavy episodic alcohol exposure i.e. ≥7 drinks/ week and/ or ≥4 drinks on 2 or more occasions; other neuro-teratogen exposures [dilantin, etc.]</i>) <input type="checkbox"/> Probable Risk (i.e. <i>reported lower quantities or variable patterns of alcohol exposure</i>) <input type="checkbox"/> Unknown / Suspected Exposure (e.g. <i>higher-risk environments; birth mother deceased, maternal addiction/mental health issues in child-bearing years; other drug exposures; sibling with FASD; etc.</i>)
Postnatal Exposure to Environmental Agents	<input type="checkbox"/> Confirmed Exposure to other neurotoxins (e.g. <i>heavy metals or medications with neurodevelopment effects - lead, mercury, phenobarbitol, etc.</i>)
Dysmorphic Features: Recognizable Patterns Associated with Neurodevelopmental Concerns	<input type="checkbox"/> Characteristic FAS Triad (<i>palpebral fissures, philtrum, lip</i>) <input type="checkbox"/> Suspected syndrome: other anomalies of frontonasal region (i.e. <i>eyes, nose, premaxilla/ palate</i>) or recognizable pattern of anomalies (e.g. <i>22Q, Dubowitz, Noonan, Williams</i>) <input type="checkbox"/> Microcephaly <5 %ile <input type="checkbox"/> Macrocephaly >95 %ile
Growth Retardation	<input type="checkbox"/> Defined as a height and/ or weight below the 10th %ile when corrected for gestational age (up to age 2)

Please mail or fax Referral Form (Page 1 and 2) and send copies of all relevant consults, reports and medical investigations to:
Northern Health Assessment Network (NHAN), 1444 Edmonton Street, Prince George, BC V2M 6W5
PH: 250-565-5827 FAX: 250-565-5702