Western Health

DEVELOPMENTAL HEALTH

❒ Corner Brook & North
3rd Floor, WMRH
P.O. Box 2005
Corner Brook, NL A2H 6J7
Phone: (709)784-5284
Fax: (709) 637-5155

❒ Stephenville & South
Rehabilitation Annex
127 Montana Drive
Stephenville, NL A2N 2T4
Phone: (709) 643-8690
Fax: (709) 643-3944

PRESCHOOL REFERRAL FORM

This referral will be received through a central intake process and it will be determined which services will be required for further assessment and intervention based on the information provided.

Check here to confirm client's caregiver(s) has been informed of this referral ❒

NAME: _____ GENDER: _____
(First) (Middle) (Last)

ADDRESS: _____ DOB: _____/_____/_____
YYYY MM DD

_____ PHONE: _____

MCP: _____ E-MAIL: _____

NOK: _____ RELATIONSHIP: _____

❒ Hearing
- ❒ Ear infections
- ❒ Ototoxic medications
- ❒ Hearing difficulty suspected
- ❒ Other _____

❒ Cognitive
- ❒ Delayed developmental milestones
- ❒ Decreased attention to task or hyperactivity
- ❒ Early risk factors
- ❒ Other _____

❒ Social/Interpersonal
- ❒ Play skills
- ❒ Difficulty with peer interactions
- ❒ Behaviour
- ❒ Other _____

❒ Self-Help
- ❒ Feeding/eating
- ❒ Toileting
- ❒ Dressing
- ❒ Other _____

❒ Physical
- ❒ Delayed developmental motor milestones
- ❒ Abnormal muscle tone
- ❒ Fine motor
- ❒ Balance/Coordination
- ❒ Other _____

❒ Communication
- ❒ Decreased vocabulary/sentence length
- ❒ Trouble pronouncing sounds
- ❒ Difficulty following directions
- ❒ Stuttering
- ❒ Other _____

❒ Sensory Processing/Self-Regulation

Is this referral being made to query a diagnosis of Autism Spectrum Disorder (ASD)? ❒ Yes ❒ No
Has a referral already been made to Janeway Outreach Services (Physiotherapy/Occupational Therapy)? ❒ Yes ❒ No
History/Comments:

_____

_____

Referral Source: _____ Phone: _____

Address: _____ Date of Referral: _____

For office use only ❒ **Eligible** ❒ **Not Eligible**

Developmental Health ONLY

Referral to: _____ Comments: _____

_____

Referral Source: _____ Date: _____