



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: _____