

# Rehabilitation Services Request

## Paediatric Team - Neuromotor and Autism

**Stan Cassidy Centre For Rehabilitation**



800 Priestman Street  
Fredericton, N.B.  
E3B 0C7  
Tel: (506) 452-5225  
Fax: (506) 452-5190

**Language Preferred:**

English  No preference

French

Family/patient consent to referral

**Parent/Guardian Signature:** \_\_\_\_\_

1<sup>st</sup> Referral

Re-Referral

Name of Patient: \_\_\_\_\_  
(last name, first name)

Address (home): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Current client location (home, hospital, other): \_\_\_\_\_

Contact person: \_\_\_\_\_

Telephone: (home) \_\_\_\_\_ (work) \_\_\_\_\_

Medicare: \_\_\_\_\_ Exp. Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_  
                                dd                          mm                          yy

School: \_\_\_\_\_

**DIAGNOSIS:** (must have a specific Neurological diagnosis): Please include MRI, CT Scan, Consult Notes (if applicable):

**SPECIFIC REASON FOR TERTIARY REFERRAL** (complex need requiring multi disciplines including Medical Specialist; intensity; specialized equipment; and/or expertise not available in the community): Please describe strategies / interventions that have been attempted to respond to the concern:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**CURRENT THERAPY SERVICES** (includes Hospital Services, ISD/Child and Youth Team, Private Practices, School, etc.)

**\*Local Services are REQUIRED in order to provide consultation**

Therapist/Physician	Discipline	Aware of Referral / Requesting Consult?	Consent from family to contact?
	Family Physician		
	Neurologist		
	Paediatrician		
	Orthopedic Surgeon		
	O.T.		
	P.T.		
	R.D.		
	SLP		
	S.W.		
	Resource Teacher		
	APSEA		

Person requesting Service: \_\_\_\_\_  
  Print    Telephone #                          dd          mm          yy

Referring Physician / or  
Director of ESS                          \_\_\_\_\_  
  Signature    Print or stamp name                          dd          mm          yy

(for Autism Team school consultations only)

**\*\*\* Incomplete Referrals Will Be Returned For Completion Prior To Acceptance \*\*\***