Centre universitaire de santé McGill
McGill University Health Centre

☒ HME MCH ☐ HGM MGH ☐ HRV RVH
☐ HNM MNH ☐ ITM MCI ☐ CL LC

Montreal Children's Hospital

Brain Development Behaviour (BDB) Centralized Intake Referral Form

1001, boul. Décarie, Room **A04-3140**
Montreal, Québec, H4A 3J1

Telephone: (514) **412- 4496**
Fax: (514) **412-4136** Email:bdbci@muhc.mcgill.ca

Referral date (yyyy/MM/dd):

Patient Information (please print):

Date of birth:	MCH File no.
Last name, First name	
Current address / City, Province / Postal Code	
Home telephone number / Other telephone number	
Email	
Language: French ☐ English ☐ Other: _____ Interpreter needed ☐	

Please describe your concerns:

Please attach any additional information on a separate page.

Please check all that apply:

☐ ***Developmental concerns*** ***(0-5 years only)***

- ☐ **1-** Child has gross motor and/or fine motor delay
- ☐ **2-** Child presents with abnormal motor exam (specify below) :
  - ☐ early handedness ☐ spasticity
  - ☐ weakness ☐ weakness with hypotonia
  - ☐ other: _____
- ☐ **3-** Child has a speech/language delay
- ☐ **4-** Child has significant behavioural or emotional difficulties
  Describe: _____
- ☐ **5-** Child requires autism evaluation and /or autism is suspected for the following reasons:
  - ☐ Significant social difficulties
  - ☐ Communication limitations
  - ☐ Unusual behaviour / play

☐ Parents have been informed of the suspicion of autism

☐ ***Hearing test only is required***

- ☐ Parents suspect hearing loss
- ☐ Failed hearing test elsewhere. Please specify: _____
- ☐ Child presents a high risk of having hearing loss:
  - ☐ Family history of hearing loss
  - ☐ Ototoxic medication
  - ☐ Meningitis
  - ☐ Complicated neonatal course
  - ☐ Cranio-facial abnormalities
  - ☐ Any medical conditions associated with hearing loss
    Please specify: _____
  - ☐ Other: _____
- ☐ History of otitis media
- ☐ Central Auditory Processing evaluation has been recommended

☐ ***Risk Indicators***

- ☐ Child spent time in an NICU after birth
- ☐ Child has a microcephaly/macrocephaly
- ☐ Child appears to have dysmorphic features
- ☐ Child has experienced an afebrile seizure
- ☐ Child has lost, over time, previously acquired developmental skills (i.e. developmental regression)
- ☐ Family history in a close relative (first degree or sibling of parent) of intellectual disability, autism, or cerebral palsy
- ☐ Child has severe delay (i.e. developmental skills are less than a third that is expected for chronological age)
- ☐ Other: _____

Referral Source:

Name of Physician (please print):	Licence number:
Address:	
Telephone number:	Fax number:
PARENTS ARE INFORMED OF THIS REFERRAL AND AGREE ☐	Signature: