PEDIATRIC SCREENER

Referrals to the Pediatric clinic must be submitted by a physician or nurse practitioner

Child's First and Last Name:

Date of Birth: **Health Card #:**

EMHware #:

Name of Primary Care Provider (please included provider #):

Clinic/Hospital:

Address:

Phone Number: **Fax:**

Please submit any pertinent history and findings on physical examination, such as lab work, imaging, medication list, etc. as this is requested by the Pediatrician.

Which of the following does the child present with?		
	developmental delay in two (2) or more areas	please explain:
	new behavioural concern of ADHD	
	new behavioral concern of Anxiety	
	complex motor delay(s)	
	concerns for Cerebral Palsy	
	concerns for Autism **Requests for Autism diagnostic assessments will filter through the FIREFLY Autism Diagnostic Hub and be assigned to the pediatrician as appropriate.*	
	Other:	Please explain:
Additional referral information:		
	a FIREFLY clinician has advocated for this referral – please return this screener and other requested information to (Name of Clinician): Fax number:	
Signature of referring physician/nurse practitioner:		**Date:**

If this is a referral from a third party provider and the child/youth is not yet a client of FIREFLY, please complete a *General Referral Form* and fax all documentation to FIREFLY's Centralized Intake at 1-866-470-1783 or by email to intake@fireflynw.ca.

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