DEVELOPMENTAL BEHAVIOURAL REFERRAL

Date		
Completed By	Role: Paediatrician/GP	How long
Other professionals involved with the child (e.g. psychologist, OT, speech therapist)		

Reason for this referral List a maximum of 3 things that you want from this consultation (list target behaviours/emotional issues)

1.

2

3

Describe briefly:

Duration of Current problems

☐ 1 – 3 months ☐ 3 – 6 months ☐ 6 – 12 months ☐ 12 + months

Known medical, surgical or developmental Diagnosis

SPEECH PROBLEMS: Describe

INTELLECTUAL DISABILITY Diagnosis: ☐ No information available

Age when diagnosis first made _____

Cause of intellectual disability (if known) _____

Has genetic testing been done? ☐ No ☐ Yes Date (yyyy-mon-dd) _____

Results _____

Developmental Disability Information (Please enclose a copy of any testing, if available)

IQ Testing Full Scale Score_____ ☐ No information available

Other testing (Adaptive, speech language, physiotherapy, Occupational Therapy, etc)

Test Administered	Date	Examiner	Results	

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ASD: Has the young person been diagnosed as suffering from an Autism spectrum disorder? No ☐ Yes (if available please enclose report)

Family History or Mental Illness, Developmental Disabilities, Neurological Illness or Seizures

List biological relatives who have a history of mental illness, mental handicap developmental disability, neurological illness or Seizures. This includes suicide attempts, severe substance abuse, psychiatric hospitalization and or treatment

☐ No information available

Relationship to patient	Illness	Treatment Date

Pregnancy and Delivery

☐ No information available Duration of Pregnancy (in months) _____

During pregnancy was alcohol, drugs or medications used?

☐ Don't know ☐ No ☐ Yes _____

Birth weight _____kg	Apgar Score ☐ 1 minute ☐ 5 minutes
Delivery ☐ Spontaneous ☐ Induced ☐ Caesarean	Complications for pregnancy or delivery ☐ No ☐ Yes _____

Early Development

Milestones ☐ No information available

Sat Up	Walked	1st word	Talked (Phrase)	Trained Urine	Trained Faeces

Educational History List school/vocational placements attended ☐ No information available

Name	Grade Attended	Comments

Professional	Start Date	End Date (if applicable)	Role, frequency of consults and interventions tried

Agencies involved (e.g. BIST, respite)	Admission Date	Discharge Date	Comments: Frequency of contact, effectiveness of their interventions

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Medical History	No	Yes	Describe
Seizure Disorder	☐	☐	
Abnormal EEG	☐	☐	
CT Scan	☐	☐	
MRI	☐	☐	
Tics or Tremors	☐	☐	
Any other type or neurological troubles e.g., headaches	☐	☐	
Specific communication disorder (e.g .inability to talk)	☐	☐	
Heart problem	☐	☐	
Respiratory problem (eg. Asthma)	☐	☐	
Stomach or intestinal problems	☐	☐	
Gynaecological problems (in teenage girls)	☐	☐	
Urinary problems	☐	☐	
Skin problems	☐	☐	
Orthopaedic problems	☐	☐	
Arthritis	☐	☐	
Allergies	☐	☐	
Impaired vision	☐	☐	
Impaired hearing	☐	☐	

Past Hospitalizations (Psychiatric/Medical/Surgery)

Date	Name of Hospital	Describe Surgery or Reason for Hospitalization

Current Physical and Mental Function
Consider the previous 3 months in completing this inventory

Physical Function	Concerns
Sleep	
Appetite	
Mood	
Thoughts (Unusual)	
Aggression	
Energy Level	
Concentration Ability	
Bowel and Bladder Concerns	
Menstrual Concerns	
Sexuality	

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Current Medications					
Medications	**Dose**	**Times/ Day**	**Effect**	**Adverse effects**	**Date Started**

Previous Trials of Medications				
Medications	**Dose**	**Start Date**	**End Date**	**Describe Result**

Name of Referring doctor	Signature	Date

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ADDITIONAL MENTAL HEALTH INFORMATION

Are there recent changes to mood, sleep and level of activity for the past 2 to 3 weeks or longer? If yes give details
Has there been a recent decrease in functional ability (speech, communication, self care etc) ? If yes give details
Has been a recent increase in repetitive and ritualistic behaviours If yes give details

Name of Referring doctor	**Signature**	**Date**