

Enhanced 18-Month Well-Baby Visit Referral Form East Parry Sound Area

Please fax completed referral to 1-888-668-6281

Office Use Only For transmission difficulty please call OKP Children's treatment centre (705) 746-6287 or Fax (705) 746-5324	
Date Referral Received:	Initial:
Date Parent contacted:	Initial:
Date Provider contacted:	Initial:

Infant/Child's First Name	Middle Initial	Last Name
DOB: DD/MM/YYYY:	Referral made to Paediatrician: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Gender:	Rourke Completed: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Parent/Guardian: Full Name	Nipissing Screen Completed: <input type="checkbox"/> Yes <input type="checkbox"/> No (Please attach completed screening)	
	Mailing Address (Street No. and Name)	Home Tel. No. (including area code):
		Alternate number:
Provider Information:		Date of Referral:
		Form Completed By:
X – Presenting concern(s)		
North Bay Parry Sound District Health Unit 1-800-563-2808 <input type="checkbox"/> Oral Health Programs (HSO: Healthy Smiles Ontario; Dental Clinic) <input type="checkbox"/> Parenting <input type="checkbox"/> Nutrition <input type="checkbox"/> Breastfeeding Support		One Kids Place Children's Treatment Centre (OKP) 1-866-232-5559 <input type="checkbox"/> Speech-Language Pathology <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Physiotherapy
HANDS TheFamilyHelpNetwork.ca 1-800-668-8555 <input type="checkbox"/> Infant and Child Development Services <small>Sundridge-Novar including Magnetawan, Sprucedale, Emsdale, Kearney areas</small> <input type="checkbox"/> Children's Mental Health		Infant and Child Development Services, Nipissing 705-472-0910 <input type="checkbox"/> Infant and Child Development Services <small>Callander-South River including Port Loring, Restoule, and Chisholm areas</small>
Comments/Other Concerns:		Was this referral made based on findings from an Enhanced 18-Month Well Baby Visit? <input type="checkbox"/> Yes <input type="checkbox"/> No

Parent has provided verbal consent for the referral and the forwarding of the referral to the appropriate agency.

Witness: _____

Date: _____



This referral will be sent to One Kids Place as the designated Best Start Lead, then forwarded on to the appropriate community service(s). Your verbal consent provides permission to share your information with the above noted community services.

Community Partners collaborating to achieve the 'Best Start' for children prenatal to 12 years!

“The personal information being collected on this form is collected under the authority of the Health Protection and Promotion Act, the Municipal Freedom of Information and Protection of Privacy Act & Personal Information Protection & Electronic Documents Act. This information shall be used to ensure necessary health care measures are attained. Questions covering the collection of this information may be directed to One Kids Place, 400 McKeown Ave, North Bay, Ontario, P1B 0B2 Phone: (705) 476-5437 or 1-866-626-9100”