Hello Speech
DEVELOPMENTAL SERVICES

PHYSICIAN REFERRAL FORM

Pediatric developmental services

PATIENT & CAREGIVER INFORMATION

Child full name *

Date of birth (YYYY-MM-DD) *

Ontario health card number (OHIP)

Version code

Parent / guardian name

Parent / guardian phone

Parent / guardian email

REFERRING PHYSICIAN INFORMATION

Referring physician full name *

OHIP billing number

Clinic / practice name

Clinic phone

Clinic fax

REQUESTED SERVICE(S)

- ☐ Speech & Language Therapy
- ☐ Occupational Therapy
- ☐ Behaviour Consultation
- ☐ Parent Coaching
- ☐ Autism Diagnostic Assessment
- ☐ Other / Unsure

For autism diagnostic assessment: receiving pediatrician - Dr. Wang (Midtown Pediatrics).

REASON FOR REFERRAL / RELEVANT CLINICAL CONCERNS

Referring physician signature / printed name *

Date (YYYY-MM-DD) *

Please attach relevant clinical reports, if available. * Required for physician referral.

ASD diagnostic assessments require physician referral; other Hello Speech services also accept self-referrals.

FAX REFERRALS: 437-317-9836

Phone: 647-202-2377 | intake@hellospeechgta.com | hellospeechgta.com