BALANCE Program – Referral Form

PATIENT INFORMATION:			
Date of Referral:			
Name:			
Home Address:			
Gender:		Date of Birth:	____ / ____ / ____ DD MM YYYY
Health Card # (including version code):		SH# (if available):	
Home Phone #:		Cell Phone #:	
Parent/Guardian:			
Email address:			
Preferred Language:	English ◯ French ◯		

REFERRING SOURCE:			
Self-Referral:	◯ Yes ◯ No		
Referring Health Care Provider:		Telephone #:	
Primary Health Care Provider:		Telephone #:	
Parent/Guardian aware of referral to Balance Program?		◯ Yes ◯ No	

MEDICAL INFORMATION:			
Current Weight (kg/lbs):		Current Height (cm/in):	
Body Mass Index (BMI)		Growth Chart Attached:	☐ Yes Please submit a WHO Growth Chart
Medical Concerns/Conditions and Current Medications/Supplements:			
Community Services Involved:			

All required information regarding the Balance Program can be accessed at www.hsnsudbury.ca/NEOKids . The patient will be contacted by the Pediatric ACU to have their intake appointment booked.

Fax form to: **(705) 523-7288** or email form and attachments to neokidsacu@hsnsudbury.ca