Centre de Réadaptation Marie Enfant
CHU Sainte-Justine
Université de Montréal

REQUEST FOR SERVICES

Centre de réadaptation Marie Enfant (CRME)
5200 Bélanger st., Montréal (Qué) H1T 1C9 (514) 374-1710

☐ Outpatients departments ☐ Residence and Respite Unit ☐ URFI (Intensive Functional Rehabilitation Unit)

GENERAL INFORMATION

Last Name (print):		First Name (print):	
Gender ☐ F ☐ M	D.O.B. *(y-m-d)*	Health Insurance Number (MANDATORY) Exp. :	File number, CRME or Ste-Justine *(if known)*:
Address of child's residence : street address:	City :	Province :	Postal Code :
Phone number (child's residence):		Other number : *(specify)*	
Child lives with : ☐ natural family ☐ other :	Legal guardian :* *please provide copy of legal judgement* ☐ parents ☐ mother* ☐ father* ☐ other *(specify)* :		Spoken langage(s): ☐ french ☐ english ☐ other :

PARENTS' INFORMATION

Mother's name (print)	Father's name (print)
Mother's address *(if different than above)*	Father's address *(if different)*
Home phone *(if different)*	Home phone *(if different)*
Phone number at work	Phone number at work
Other number *(specify)*	Other number *(specify)*
e-mail	e-mail

OTHER LIVING SITUATION

☐ Foster family ☐ Intermediate ressources ☐ Other *(specify)*	Address
Name of contact person (print) :	Phone number :

IF CHILD UNDER CARE OF YOUTH PROTECTION

Contact person's name (print):	Title :
Address :	Phone number :

CONSENT

☐ The client and his family have been informed of this referral and agree with the transmission of information.

Outpatients : send to AEO services via mail or fax to 514-723-7127
Residence and Respite Unit / URFI: send to admission services by mail or fax 514-723-7127

MEDICAL INFORMATION

Child's current primary diagnosis or other diagnosis or associated conditions:

Description of persistent and significative impacts on the child's lifestyle (MANDATORY):

Reason of referal:

Any special conditions regarding child and his/her family:

Did you receive previous evaluations or interventions, if so where? Describe services received if applicable. ☐ yes ☐ no
☐ CSSS (specify) :
☐ Hospital Center (specify) :
☐ Private Ressources (specify) :

Are you currently receiving evaluations or interventions, if so where? Describe services received if applicable. ☐ yes ☐ no
☐ CSSS (specify) :
☐ Hospital Center (specify) :
☐ Private Ressources (specify) :

Name of other center(s) where reference was sent (if applicable):

Reports from professionals

☐ Audiology	○ copy joined	or	○ will follow by *(date)* _____
☐ Neuropsychology	○ copy joined	or	○ will follow by *(date)* _____
☐ Nutrition	○ copy joined	or	○ will follow by *(date)* _____
☐ Occupational therapy	○ copy joined	or	○ will follow by *(date)* _____
☐ Physiotherapy	○ copy joined	or	○ will follow by *(date)* _____
☐ Psychology	○ copy joined	or	○ will follow by *(date)* _____
☐ Respiratory therapy	○ copy joined	or	○ will follow by *(date)* _____
☐ Social services	○ copy joined	or	○ will follow by *(date)* _____
☐ Education specialist	○ copy joined	or	○ will follow by *(date)* _____
☐ Speech-language pathology	○ copy joined	or	○ will follow by *(date)* _____
☐ Medical report: specialty:_____	○ copy joined	or	○ will follow by *(date)* _____
☐ Other: _____	○ copy joined	or	○ will follow by *(date)* _____

REFERRING PROFESSIONAL

Name (print)	Title (print)
Hospital, centre or clinic	
Address	
Phone	Fax
E-mail	
SIGNATURE	**DATE**