



**Complex Developmental Behavioural Conditions (CDBC)  
and BC Autism Assessment (BCAAN) Networks**

Interior Health Children's Assessment Network (IHCAN)  
Community Health and Services Building  
505 Doyle Avenue, Kelowna, BC V1Y 0C5



**PATIENT REFERRAL FORM (for children and youth up to their 19<sup>th</sup> birthday)**

\* For URGENT/EMERGENT Mental Health referrals, please refer to appropriate services(s)\*

SUPPORTING DOCUMENTATION should include:

- Your consult letter outlining areas of significant concerns or difficulties
- Page 2 of referral concerns
- Other consultations (if available) from:  IDP  SLP  OT/PT  Psychology  Other: \_\_\_\_\_

**PATIENT INFORMATION (please print)**

REFERRAL DATE: \_\_\_\_\_

Child's name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Middle) \_\_\_\_\_

Date of birth (yyyy/mm/dd): \_\_\_\_\_ BC PHN#: \_\_\_\_\_  Male  Female  Other \_\_\_\_\_

Address where child lives: \_\_\_\_\_ (City) \_\_\_\_\_ (PC) \_\_\_\_\_

Phone numbers: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Other) \_\_\_\_\_

Child lives with:  Mother  Father

Alternate/Foster Name: \_\_\_\_\_

Phone numbers: (Home) \_\_\_\_\_

(Work1) \_\_\_\_\_ (Work2) \_\_\_\_\_

(Cel 1) \_\_\_\_\_ (Cel 2) \_\_\_\_\_

(Other) \_\_\_\_\_

Legal Guardian's name & address (if different from above)

Name: \_\_\_\_\_

Address: \_\_\_\_\_

(City) \_\_\_\_\_ (PC) \_\_\_\_\_

MCFD  Other: \_\_\_\_\_

Day phone: \_\_\_\_\_ Other phone: \_\_\_\_\_

Interpreter needed?  Yes  No If yes, what language(s)? \_\_\_\_\_

**PRIMARY REASON(S) FOR REFERRAL**

- Query Fetal Alcohol Spectrum Disorder
- Query Complex Developmental Concerns
- Query Autism Spectrum Disorder

Is the LEGAL GUARDIAN aware of the primary reason for referral?  Yes  No Why not? \_\_\_\_\_

**IN ADDITION TO DIAGNOSIS, ARE THERE QUESTIONS YOU OR THE FAMILY WOULD LIKE ANSWERED?**

\_\_\_\_\_

Is hearing a concern?  Yes  No If yes, has hearing test been  Initiated  Completed

Is vision a concern?  Yes  No If yes, has vision test been  Initiated  Completed

Known Medical Diagnoses (including genetic disorders, physical impairments, etc): \_\_\_\_\_

\_\_\_\_\_

**PHYSICIAN INFORMATION**

Referring Physician's Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ BC MSC # \_\_\_\_\_

Pediatrician  Family Practitioner  Psychiatrist  Other Medical Specialist: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #s: \_\_\_\_\_ Fax #s: \_\_\_\_\_

Physician's Signature (mandatory) \_\_\_\_\_

Complex Developmental Behavioural Conditions (CDBC)  
and BC Autism Assessment (BCAAN) Networks (March 2016)

The **CDBC Program** diagnostic assessment services are intended for children and youth who have significant difficulties in multiple areas of function including those with known or suspected history of exposures to substances with neurodevelopmental effects.

Referral from **pediatricians or child psychiatrists** is required (with exceptions based on access).

CDBC Referrals require a detailed consult. Please indicate if you have concerns about the following:

- Development, Cognition, and Learning** – developmental history and current concerns
- Adaptive and Social Skills** – self care, interpersonal skills, safety, etc.
- Mental Health and Behaviour** – regulation, attention, mood, etc.
- Bio Markers** – documented or substantiated evidence of exposure to environmental agents including alcohol. Dysmorphic features, suspected syndrome or observable abnormalities. Include face and growth measurements if available (FASD specific)

Additional Comments:

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**BCAAN** provides diagnostic assessments for those with **suspected Autism Spectrum Disorder** and accepts referrals from **all physicians**.

Please indicate if you have concerns about the following:

- Mental Health/Behaviour    Cognition/Developmental Delay    Language

Please indicate your level of concern in each domain and provide examples of behaviours that support it:

<p><b>Social Communication</b></p> <p><input type="checkbox"/> Unknown/no concern</p> <p><input type="checkbox"/> Level 1 - noticeable impairments in social communication; difficulty initiating social interactions.</p> <p><input type="checkbox"/> Level 2 - moderate deficits in verbal and nonverbal social communication; limited initiation of social interactions; reduced response to social overtures.</p> <p><input type="checkbox"/> Level 3 - severe impairment in functioning; severe impairment in verbal and nonverbal social communication; difficulty initiating social connections; not responding to social overtures; inability to make friends; disconnected conversations.</p> <p>Examples: _____</p> <p>_____</p>	<p><b>Repetitive Behaviours</b></p> <p><input type="checkbox"/> Unknown/no concern</p> <p><input type="checkbox"/> Level 1 - noticeable inflexibility of behaviours cause significant interference with functioning.</p> <p><input type="checkbox"/> Level 2 - moderate inflexibility of behavior; difficulty coping with change; obvious repetitive behaviours cause impairment in functioning.</p> <p><input type="checkbox"/> Level 3 - severe inflexibility or repetitive behaviours cause significant functional issues; difficulty changing focus; extreme difficulty coping with change.</p> <p>Examples: _____</p> <p>_____</p>
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Who is concerned about these behaviours?  Guardian    School    Other professional (i.e. SLP, OT) \_\_\_\_\_

Attach copies of all documents that support this referral (i.e. school or daycare reports, speech and language reports, IDP reports).

**Please mail or fax Referral Form (Page 1 and 2) and send copies of all relevant consults, reports, and medical investigations to:** Intake: Interior Health Children's Assessment Network (IHCAN), Community Health & Services Building – 505 Doyle Ave, Kelowna, BC, V1Y 0C5 PH: 250-763-4122 FAX: 250-712-0732