

Thank you for referring to Intuitive Therapy Solutions. Complete all sections and email to inquiries@intuitivetherapysolutions.com. We will follow up within 2 business days.

SECTION 1 — REFERRING PROVIDER**Provider Name ***

First and last name

Profession / Role *

e.g. Pediatrician, SLP, Dietitian, Chiropractor

Clinic / Practice Name *

Name of your clinic or practice

Province *

Province you are referring from

Phone

Best number for case follow-up

Email *

Professional email for coordination

Preferred Contact Method☐ Phone☐ Email☐ Either**SECTION 2 — CHILD & FAMILY INFORMATION****Child's Full Name****Date of Birth ***

MM/DD/YYYY

Parent / Guardian Name ***Parent Phone *****Parent Email *****Language(s) Spoken at Home**

Include all languages spoken at home

SECTION 3 — CLINICAL REFERRAL INFORMATION**Primary Reason for Referral ***☐ Feeding / Food Refusal☐ Sensory Processing☐ Nervous System Regulation☐ Multiple Concerns☐ Other**Brief Description of Concern ***

What is the child doing or not doing? What have parents tried? What prompted referral now?

How long has this been a concern?

e.g. Since birth, 6 months, Over a year

Previous Therapy or Assessments?

OT, SLP, feeding therapy, developmental assessment

Relevant Diagnoses / Medical History

GI concerns, airway issues, NICU history, diagnoses relevant to feeding or sensory function

SECTION 4 — FUNDING & LOGISTICS**Funding Type ***☐ Private Pay ☐ FSCD ☐ Other Gov. Funding ☐ Unsure**FSCD File Active?**

Yes / No / In Application / Unsure

Urgency

Routine / Within 1-2 months / Urgent (ASAP)

SECTION 5 — ADDITIONAL NOTES**Anything Else We Should Know?***Family circumstances, communication preferences, or clinical context helpful to know***May we follow up with you after initial contact with the family?**☐ Yes ☐ No

What happens next: We will contact the family directly to schedule a complimentary fit consult. We will follow up with you if we have clinical questions. Thank you for trusting us with your families.