SMA Intensive Inpatient Program: Intake Information Form

□*Part 2 should be completed with the child/youth and family and OT and/or PT*

****This form MUST be completed and returned BEFORE your referral will be reviewed by the admissions committee**

PART 1: completed by caregiver – General Information

COMPLETED BY: _____ DATE COMPLETED: _____

Child's Name: _____ **Sex: Male□ Female □ Other□**

Date of Birth: _____ **Medical Record Number (if known):**

Diagnosis:
SMA type: □ type 1, □ type 2, □ type 3
SMN copy number: 2 copies □, 3 copies □, 4 copies □, other □

Does your child (check all that apply):

Roll	Sit	Crawl	Stand	Walk
Independently □	Independently □	Independently □	Independently □	Independently □
w/ equipment □	w/ equipment □	w/ equipment □	w/ equipment □	w/ equipment □
w/ assistance □	w/ support □	w/ support □	w/ support □	w/ support □

Comments:_____

How does your child eat/drink?

□Regular texture □Special texture/diet: _____	□G-Tube □NG Tube □GJ Tube Tube size: Type and amount of feeding/formula:	□Difficulty chewing □Difficulty swallowing □Bottle fed	□Other (cultural/religious diet implications):

Do you have any additional comments on how your child feeds?

_____

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Created: September 17, 2020
Last updated: December 1, 2020

Is your child followed by a dietitian or other health professional for weight or growth?
If so please include the professional's name and contact information here:

_____

Has your child received help for feeding/swallowing at any of the following centres? If yes, please describe recommendations given:
Holland Bloorview □
Sick Kids □
Hamilton □
Childrens treatment center □
Other □

Please list agencies/workers/therapists/private therapists that are currently working with your child or helping you: Agency (Surrey Place, LHIN, Infant Development, Schools, Hospitals, Early Abilities, Geneva Centre etc.)	**Worker/Therapist Name, title and contact information** Example: Occupational Therapist, Physiotherapist, Speech Language Pathologist, Registered Dietitian

PART 2: Therapists (OT/PT) with child/youth and family for Goal Setting

COMPLETED BY: _____ DATE COMPLETED: _____

What equipment does your client have in place or is in progress? Please include bracing. (ex. AFOs, TLSO, walker, standing frame, wheelchair, etc.)

Equipment type:	When did/will you get it?	Comments (i.e. Specify if school or home equipment, if not in place then if):

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**We request that all essential equipment is in place PRIOR to referral to the SMA Intensive Inpatient Program*

Provide a brief description of your client's recent OT/PT sessions and their progress toward specific goals (you may attach additional reports as appropriate):

_____

_____

Have any assessments been completed recently if available (please ask the family if they were completed at the hospital where they receive medical treatment)?

Assessment :	**Result/score:**	**Date of assessment & comments:**
CHOP-INTEND		
HINE (Hammersmith Infant Neurological Examination)		
HFMS (Hammersmith Functional Motor Scale)		
RULM (Revised Upper Limb Module for SMA)		
MFM (Motor Function Measure)		
6 minute walk test		

If available please list any other therapy assessments (e.g. SLP, neuropsychology etc.)

Assessment :	**Result/score:**	**Date of assessment & comments:**

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The goal of this program is to support individuals work toward specific functional goals. Please include at least 3 specific motor functional goals developed with the child/youth and family and therapy team (please include additional pages as needed):

1. _____

2. _____

3. _____

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