Holland Bloorview
Kids Rehabilitation Hospital

Selective Dorsal Rhizotomy – Ambulatory Referral Screen for Outpatient

Client name: _____ **DOB:** _____

Diagnosis of Spastic Diplegic Cerebral Palsy ◯ Yes ◯ No Other: (please specify) _____

Gross Motor Function Classification Scale (GMFCS) Level ◯ II ◯ III Other: (please specify) _____

Client is between the ages of 3 and 8 years ◯ Yes ◯ No

Client is able to actively participate in therapy? ◯ Yes ◯ No

Comments:

Does the client exhibit any involuntary movements at rest? (for example dystonia) ◯ Yes ◯ No

Please let us know if an MRI of the brain has been completed and what it showed
*if possible please include copy of MRI report ◯ Yes * ◯ No

Findings:

Any other information that would aid us

Comments:

REF SDR