

Client Name: _____

Date of Birth: _____

Dental Services: Pre-Assessment Information Form

Client's Height (in centimeters): _____ Client's Weight (in kilograms): _____

Does the child have: Behavioural issues Anxiety Other: _____

Please tell us about the child's previous experiences in health care settings

Has the child received dental services? If yes: When: _____ Where: _____ Were there behavioural issues? _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is therapeutic stabilization required at dental or medical appointments?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Has the child received sedation prior to dental services? If yes: When: _____ Where: _____ Were there any issues? Explain: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Please tell us about your child's behaviour

How does the child react to new environments? _____ _____		
Does the child demonstrate physical aggression? If yes, are they physically aggressive towards: <input type="checkbox"/> Self? <input type="checkbox"/> Others? If yes, how do they act when aggressive? _____		



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Please tell us about the child's communication skills

What is the best way to communicate with the child?

Verbal

Communication device, please specify: _____

Sign language

Other: _____

How does the child communicate that they are in pain?

Your referral will be processed when this completed form has been received. Thank you for your prompt reply.

Please fax or return this form to the address below. For privacy reasons, we do not recommend that you send this by email.

**Client Appointment Services
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