

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?

☐ Yes☐ No

If yes:

When: \_\_\_\_\_ Where: \_\_\_\_\_

Were there behavioural issues?

\_\_\_\_\_

Is therapeutic stabilization required at dental or medical appointments?

☐ Yes☐ No

Has the child received sedation prior to dental services?

☐ Yes☐ No

If yes:

When: \_\_\_\_\_

Where: \_\_\_\_\_

Were there any issues? Explain: \_\_\_\_\_

\_\_\_\_\_

☐ Yes☐ 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: ☐ Self? ☐ Others?

If yes, how do they act when aggressive? \_\_\_\_\_

\_\_\_\_\_



\* R E F O U T P \*

--	--	--

**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  
 Holland Bloorview Kids Rehabilitation Hospital  
 150 Kilgour Road, Toronto, ON.  
 M4G 1R8  
 Fax: 416- 422-7036**

