

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 <input type="checkbox"/>	Independently <input type="checkbox"/>	Independently <input type="checkbox"/>	Independently <input type="checkbox"/>	Independently <input type="checkbox"/>
w/ equipment <input type="checkbox"/>	w/ equipment <input type="checkbox"/>	w/ equipment <input type="checkbox"/>	w/ equipment <input type="checkbox"/>	w/ equipment <input type="checkbox"/>
w/ assistance <input type="checkbox"/>	w/ support <input type="checkbox"/>	w/ support <input type="checkbox"/>	w/ support <input type="checkbox"/>	w/ support <input type="checkbox"/>

Comments: _____

How does your child eat/drink?

<input type="checkbox"/> Regular texture <input type="checkbox"/> Special texture/diet: _____	<input type="checkbox"/> G-Tube <input type="checkbox"/> NG Tube <input type="checkbox"/> GJ Tube Tube size: Type and amount of feeding/formula:	<input type="checkbox"/> Difficulty chewing <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Bottle fed	<input type="checkbox"/> Other (cultural/religious diet implications):
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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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