Québec

ADDITIONAL INFORMATION REGARDING THE REQUEST FOR SERVICES
CLIENTS WITH DEVELOPMENTAL COORDINATION DISORDER (DCD)

Information concerning the youth

Last name, First name: _____

Date of birth : _____

File number : _____ Health insurance number : _____

A youth's eligibility in the CRDP cannot be based solely on the diagnosis of DCD. Given the specialized rehabilitation mandate, eligibility is determined by the severity of the functional impairment. In this context, at the time of application, the youth must be in a situation of significant impairment.

For physical rehabilitation needs, the request is directed to:

☐ Marie-Enfant Rehabilitation Center ☐ Lethbridge-Layton-Mackay Rehabilitation Center

Youth's current profile

- ✓ Is the **medical** diagnosis of DCD confirmed? ☐ Yes ☐ No
- ✓ A complete occupational therapy evaluation less than one year old is attached to the application (including standardized test results)? ☐ Yes ☐ No
- ✓ Significant functional impacts are present in the execution of life habits, placing the youth in a situation of **significant impairment** despite the adaptations/compensations put in place in the environment? ☐ Yes ☐ No
- ✓ Functional impacts must **clearly be explained by motor difficulties/motor organization and are not best explained by a lack of collaboration/understanding/attention. Functional impacts exceed those associated with one or more other diagnoses (e.g., ASD, ADHD, ID, etc.)?** ☐ Yes ☐ No
- ✓ The child has the **rehabilitation potential to benefit from a cognitive problem-solving type approach** (COOP approach) as well as the ability to collaborate? ☐ Yes ☐ No
- ✓ In the context of a request for service **for a child with a dual diagnosis (DCD and ASD/ID)**, is educational and/or psychosocial support from a network partner required to promote the child's full potential to benefit from rehabilitation in physical disability?

☐ Yes, prior to being admitted in the CRDP* ☐ Yes, in collaboration with the CRDP *

☐ Existing services ☐ Not required

** If yes, has a referral for the child and family also been made to the ID-ASD-PD Access Desk in their territory?*

☐ Yes ☐ No

Referent information

Last name, first name:_____ Telephone :_____

Establishment : _____ Date : _____