DOGWOOD PLACE

Child and Youth Development Centre

Infant Development Program
Speech and Language Program
Occupational Therapy Program
Physiotherapy Program
FASD Key Worker
Supported Child Development Program

REFERRAL FORM

Date: _____

Please indicate which program(s) you are referring to. Please √

- ☐ Speech and Language Program (birth to school entry)
- ☐ Occupational Therapy Program (birth to school entry)
- ☐ Physiotherapy Program (birth to school entry)
- ☐ Feeding Consult (Occupational and Speech and Language Programs, birth to school entry)
- ☐ Infant Development Program (birth to 3 yrs.)
- ☐ Supported Child Development Program (birth to 12 yrs.)
- ☐ Fetal Alcohol Spectrum Disorder Key Worker (birth to 19 yrs.)

Does child qualify for Indigenous services? ☐Yes ☐ No

Would parent/guardian prefer to be connected to Laichwiltach Family Life Society? ☐Yes ☐ No

Name of Child: _____ Gender: _____

Date of Birth: _____ *(Month/day/year)* Age at referral: _____

Name of Legal Guardian(s): _____ Phone Number: _____

Name of parent/guardian _____ **Email:** _____

Phone: Home: _____ Work: _____ Cell: _____

Address: _____ City: _____ Postal Code: _____

Mailing Address (if different) _____ City: _____ Postal Code: _____

Name of parent/guardian _____ **Email:** _____

Phone: Home: _____ Work: _____ Cell: _____

Address: _____ City: _____ Postal Code: _____

Mailing Address (if different) _____ City: _____ Postal Code: _____

Family Physician: _____ Physician Phone Number: _____

Referral Source (Name or Agency): _____ If agency, contact name: _____

Referral Source address: _____ Phone number: _____

Reason for referral (please complete this section): _____

_____

_____

_____

Does the parent/guardian agree with this *referral* and *referral reason*? ☐ Yes ☐ No

Is this child attending a child care centre? ☐Yes ☐No ☐Waitlisted

Name of centre _____ Days and times attending: _____

c.c.: _____ _____

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www.cradacl.bc.ca
Administered by the Campbell River and District Association for Community Living