DOGWOOD PLACE

Child and Youth Development Centre

Family Resource Program
Infant Development Program
Speech and Language Program
Occupational Therapy Program
Physical Therapy Program
Community Access Services
FASD Key Worker
Supported Child Development Program

REFERRAL FORM

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

- ☐ **Infant Development Program (birth to 3 years)**
- ☐ **Speech and Language Program (birth to school entry)**
- ☐ **Physical Therapy Program (birth to school entry)**
- ☐ **Occupational Therapy Program (birth to school entry)**
- ☐ **FASD Key Worker (birth to 19 years)**
- ☐ **Supported Child Development Program (birth to 12 years)**

Date:_____
Client Name:_____
B.C. Care Card - Personal Health Number:_____
Birthdate:_____ Age:_____ Sex:_____
(Month/Day/Year)
Address:_____
City:_____ Postal:_____
Mailing Address (if different):_____
Phone: Home:_____ Work:_____ Cell:_____
E-mail: _____
Parents/Guardians Names (please circle one):
Mother/Guardian:_____ Father/Guardian:_____
Family Physician:_____ Physician Phone Number:_____
Referral Source (Name/Agency):_____
Referral Source Address:_____
Reason for Referral:_____

_____
_____
_____
_____
_____
_____
_____
_____

Has parent/guardian been notified prior to referral? ☐ Yes ☐ No
Would child qualify for Aboriginal Services? ☐ Yes ☐ No
If yes, would family like to be connected with them? ☐ Yes ☐ No

c.c. _____
_____

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Administered by the Campbell River and District Association for Community Living