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:____
____
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____
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____
____
____

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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