# REFERRAL

The Centre offers therapeutic and support services to children with developmental disabilities and other special needs (and their families). For more information see The Centre's website at www.centreforchilddevelopment.ca or phone (604) 584-1361 ext. 2231.

**This referral will NOT be processed without the appropriate signed consents on page 4**

**To avoid delays please complete ALL applicable sections of this form AND ensure that we receive relevant consultation reports/letters/hospital reports (physician, therapists).**

## Child's Information

**Child's Name**: _____ Date of birth: _____ ☐ Male ☐ Female
Please print First Last month/day/year

**Does this child have a diagnosis:** No ☐ Yes ☐ (please specify)_____

**Child resides with:**

☐ Both Parents ☐ Mother only ☐ Father only ☐ Foster Family ☐ Other_____

**The Legal Guardian for this child is**:

☐ Both Parents ☐ Mother only ☐ Father only ☐ Gov't Guardian ☐ Other_____

**1. Parent(s) or Legal Guardian's Name(s)** _____
Please print First Last

☐ Mother ☐ Father ☐ Gov't Guardian (e.g. MCFD Social Worker) ☐ Other: _____

Address: _____ City: _____ Postal Code: _____

Phone (Home): _____ (Work): _____ (Cell): _____

E-mail: _____

I consent to receive communications from The Child Development Foundation of BC, which raises funds to support The Centre for Child Development. **Yes** ☐

**2. Parent(s) or Legal Guardian's Name(s) Foster Parent or other (if applicable)** _____
Please print First Last

☐ Mother ☐ Father ☐ Gov't Guardian ☐ Foster Parent ☐ Other: _____

Address: _____ City: _____ Postal Code: _____

Phone (Home): _____(Work): _____(Cell) _____

You may be eligible for additional services and/or interpreter services. Is this child an Aboriginal person, that is, First Nations (North American Indian), Métis or Inuk (Inuit)? Yes ☐ No ☐

Language(s) spoken at home: _____Would an interpreter be helpful? Yes ☐ No

Child's race/ethnicity: mark all that apply: (optional)

Chinese ☐ Filipino ☐ Korean ☐ South Asian ☐ Caucasian ☐ Other _____
(e.g., East Indian, Pakistani, Sri Lankan, etc.)

Child's Name: _____ Date of birth: _____
Please print First Last month/day/year

**Services or consultations requested and specific reasons for requesting each service:** ***Please note that The Centre for Child Development will determine eligibility and appropriate service(s) for this child/youth dependent on diagnosis, medical reports and other information received.***

**Communication Therapy :** *e.g. no meaningful communication; only uses pointing/gesturing; problems with clearness of speech, or using words and sentences, or understanding and following directions).*

**Specific reason:**

Has your child been referred for a hearing assessment? Yes ☐ Where: Public Health Unit ☐
Other _____

No ☐ A hearing referral will be made on your behalf ☐

**Eating Skills Team (Dr's referral and Dr's medical report required)** *(concerns regarding safety of swallowing e.g. gagging/coughing with foods, recurrent respiratory infections; delayed oral-motor skills resulting in significant problems with nutrition/hydration, tube feeding)*

**Specific reason:**

**Fetal Alcohol Spectrum Disorder/Complex Developmental Behavior Condition Key Worker** *(Documentation of diagnosis or pending assessment required)*

**Specific reason:**

**Family Services:** *Available to a limited number of families with multiple barriers to accessing emergency services, funding and other needed services.*

**Specific reason:**

**Occupational Therapy:** *(e.g. problems with using their hands, crayons, scissors, use of toys, attention span, playing with others, dressing, toileting, sleeping)*

**Specific reason:**

**Physical Therapy:** *(e.g. problems with body movement, strength, muscle tone, or gross motor development such as rolling/sitting/standing)*

**Specific reason:**

Child's Name: _____ Date of birth: _____
Please print First Last month/day/year

**Preschool:** If you are interested in registration at The Centre or Lookout Preschool, please contact the Director of Preschools at (604) 584-1361 local 2230.

**Psychology/Parent Support :**
*Does your child have behavioural or emotional challenges. Please describe the behaviour and when it is most likely to occur and how often*: *(e.g. tantrums at bath time, anxiety before going to school)*
*Social Relationships/interactions*: *(e.g. eye contact, friendships, reading social cues, turn taking, empathy, emotions)*
**Specific reason:**

**Supported Child Development:** *Is this child registered for or attending or looking for a Daycare/Preschool/School Age Program? Do you need help to find a Daycare/Preschool/School Age Program? Having difficulty compared to his/her peers? In jeopardy of being asked to leave a setting?*
**Specific reason:**

## CONSENT TO RELEASE AND OBTAIN INFORMATION

I, the undersigned, do hereby authorize The Centre for Child Development to **release** reports and verbally share medical/educational information regarding my child to agencies as noted below.

I also authorize The Centre for Child Development to **obtain** medical/educational information regarding my child from agencies noted below.

**This referral will NOT be processed without the appropriate signed consent on page 4**

| **SERVICE PROVIDER/AGENCY** (Please list names of all service providers) | **RELEASE TO** (please initial all selected recipients) | **OBTAIN FROM** (please initial all selected sources) |
|---|---|---|
| **Infant Development Program** | | |
| **Supported Child Development Program** | | |
| **Preschool/daycare/school** | | |
| **School District** | | |
| **Surrey Memorial Hospital** | | |
| **BC Children's Hospital** | | |
| **Sunny Hill Health Centre for Children** | | |
| **Orthotist** | | |
| **Foster parent(s)** | | |
| **MCFD Social worker** | | |
| **Child's doctors per pg 4 OR please list *first* and *last* names:** | | |
| | | |
| | | |
| **Other professionals involved with child (please list):** | | |
| | | |
| | | |
| | | |

Child's Name: _____ Date of birth: _____
Please print First Last month/day/year

**Family Doctor:** _____ Phone: _____

Address: _____ Postal Code: _____

**Pediatrician:** _____ Phone: _____

Address: _____ Postal Code: _____

**<u>This referral will NOT be processed without the appropriate signed parent/Legal Guardian's/Child's (14 or over) consent below</u>**

**Parent/Legal Guardian's (Custodial Parent, Government Guardian, Other) consent to referral and consent to obtain and release information on behalf of the child**

Print Name: _____
First Last

Signature: _____ Date: _____
month/day/year

**Child consent to referral (age 14 or over), if appropriate:**

Print Name: _____
First Last

Signature: _____ Date: _____
month/day/year

**Please Note:** Only children/youths able to form consent and/or their Legal Guardian can make a referral for any/all services provided by The Centre for Child Development. Professionals or others who provide related information do so as expert advisors only and are not deemed as referral sources. T he Centre reserves the right to require proof of guardianship or proof of change of guardianship at its discretion.

**Associated Professional(s) assisting Legal Guardian(s) or child (14 years of age or over where appropriate) to make referral**

Name: _____ Date: _____
Please print First Last month/day/year

Title/Relationship: _____

Address: _____ City: _____ Postal Code: _____

Phone (Work) _____ E-mail: _____

**Forward this completed form by FAX to (604) 583-5113 or mail to:**
**The Centre for Child Development, 9460 140th Street, Surrey, B.C. V3V 5Z4**