# REFERRAL FORM

The Centre offers therapeutic and support services to children with developmental disabilities. We also offer support to children with other special needs and their families. Visit www.the-centre.org or call 604-584-1361, ext 2231 for more information.

Please review and fill out all applicable sections of this form. Further, we need to receive all relevant reports: consultations, letters, hospital reports, etc., from your physicians or therapists to avoid any delays. This form is fillable. You may complete it on your computer and then print it out.

## CHILD INFORMATION

*Name of Child* _____ Date of birth _____
*Please print* *First* *Last* *YY / MM/ DD*

*Gender*: Male ☐ Female ☐ Other ☐ (*please specify*) _____ Preferred pronouns: _____

*Does the child have a diagnosis*? No ☐ Yes ☐ (*please specify*) _____

*The child lives with*:

☐ Both parents ☐ One parent only ☐ Foster Family ☐ Other _____

*The Legal Guardian for this child is*:

☐ Both parents ☐ One parent only ☐ Gov't Guardian ☐ Other _____

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

Address: _____ City: _____ Postal Code: _____

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

Preferred Email(s): _____

*Parent(s), Legal Guardian's, Foster Family's Name(s)* _____
*Please print* *First* *Last*

Address: _____ City: _____ Postal Code: _____

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

Preferred Email(s): _____

*I consent to receive communications from The Centre for Child Development by email* Yes ☐ No ☐

*I consent to receive communications from The Child Development Foundation of BC, which raises funds to support The Centre for Child Development* Yes ☐ No ☐

Is the child Indigenous (that is, First Nations, Metis or Inuk)? Yes ☐ No ☐ They may be eligible for additional services and/or interpreter services.

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

(*Optional* - Child's race / ethnicity: please mark all that apply

Caucasian ☐ Chinese ☐ Filipino ☐ Korean ☐ South Asian ☐ Other ☐

Please specify any other ethnicities(s):

Name of Child _____ Date of birth _____

## Services or Consultations Requested

Please provide specific reasons why you are requesting services or consultations at The Centre. The Centre for Child Development will then determine eligibility and the appropriate service(s) for your child/youth depending on their diagnosis, and any medical reports and other information that we receive.

**Communication Therapy** Does the child have no meaningful communication? Use only pointing/gesturing? Have problems with being understood or understanding words and sentences? Have difficulty following directions?

*SpecificReason(s) or check here if no concerns* ☐

If you have concerns about your child's hearing, please contact Fraser Health at: https://www.fraserhealth.ca/health-topics-a-to-z/children-and-youth/hearing-services-for-children

**Feeding and Nutrition Team:** A **pediatrician referral and medical report is required.** Do you have concerns regarding the child's ability to swallow safely, e.g., gagging/coughing, and may have recurrent respiratory infections? Does the child have delayed oral-motor skills resulting in significant problems with nutrition/hydration, tube feeding?

Specific Reason(s) or check here if no concerns ☐

**Fetal Alcohol Spectrum Disorder / Complex Developmental Behaviour Key Worker** Documentation of a diagnosis or a pending assessment is required.

*Specific Reason(s) or check here if no concerns* ☐

**Family Services** The Centre is able to provide Family Services to a limited number of families facing multiple barriers to access emergency services, funding, and other services.

*Specific Reason(s) or check here if no concerns* ☐

**Occupational Therapy** Does the child have problems using their hands with crayons, scissors, or other toys? Does the child have other challenges such as attention span, playing with others, dressing, toileting, or sleeping?

*Specific Reason(s) or check here if no concerns* ☐

Name of Child | Date of birth

**Physical Therapy** Does the child have challenges with body movement, their strength, or muscle tone? Do they have gross motor development challenges such as rolling, sitting, or standing?

*Specific Reason(s) or check here if no concerns* ☐

**Psychology / Parent Support** Does your child have behavioural or emotional challenges? Please describe the behaviour in the box below and include when and how often the behaviour is most likely to occur, e.g., tantrums at bath time, anxiety before going to school. Does your child have challenges with social relationships or interactions? E.g., eye contact, friendships, reading social cues, taking turns, demonstrating empathy or emotions.

*Specific Reason(s) or check here if no conerns* ☐

**Supported Child Development** Is the child registered for or attending a daycare / preschool / school age program? Do you need help finding a daycare / preschool / school age program? Is the child experiencing difficulties compared to their peers? Is the child in jeopardy of being asked to leave a program? Please provide name of preschool or childcare program if known.

*Specific Reason(s) or check here if no concerns* ☐

## PROFESSIONAL CONTACT INFORMATION

*Family Doctor:* | Phone:
Address: | Postal Code:

*Pediatrician*: | Phone:
Address: | Postal Code:

*The Name of the Associated Professional(s)* who assisted to make the referral.

*Name:* | Date:
*Please print* *First* *Last* *YY / MM / DD*

*Title/Relationship*: | Phone (work):
Address: | City: | Postal Code:

If referral is not signed by legal guardian, associated professional must check this box confirming the legal guardian has consented to the referral. ☐



Consents to obtain/release information must be signed by legal guardian

Name of Child _____ Date of birth _____

# 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 the agencies I have noted below.

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

| SERVICE PROVIDER OR AGENCY | RELEASE TO | OBTAIN FROM | Email |
|---|---|---|---|
| *Please list names of service providers noted below.* | *Please initial beside all providers you authorize releasing to* | *Please initial beside all providers you authorize obtaining from* | *Please initial beside all providers you authorize us to communicate with via email.* |
| BC Children's Hospital | | | |
| Sunny Hill Health Centre for Children | | | |
| Surrey Memorial Hospital | | | |
| School District *Surrey* ☐ *Langley* ☐ *Delta* ☐ *Other* ☐ | | | |
| Infant Development Program | | | |
| Supported Child Development Program | | | |
| Preschool / daycare / school – *Name:* | | | |
| | | | |
| Foster parent(s) | | | |
| MCFD CYSN Social Worker | | | |
| Child's doctors (page 3) ***OR*** list first/last name here | | | |
| | | | |
| | | | |
| Other professionals involved with child | | | |
| | | | |
| | | | |

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

***Name:*** _____
*Please print* *First* *Last*

***Signature:*** _____ Date: _____
*YY / MM / DD*

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

***Name:*** _____
*Please print* *First* *Last*

***Signature:*** _____ Date: _____
*YY / MM / DD*

**FAX the completed form to 604-583-5113**
**Or mail to: The Centre for Child Development, 9460 140th Street, Surrey, BC, V3V 5Z4**

**Please Note**: Only children/youths able to form consent and/or their Legal Guardian can make a referral for any/all services proved 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. The Centre reserves the right to require proof of guardianship or proof of change of guardianship at its discretion.