



REFERRAL FORM

For Screening/Intake Use _____

Copy for Dept _____

Internal Case Coordinator _____

The purpose of this form is to provide The Centre for Child Development (The Centre) with information as part of a screening process to assist in determining a child/youth's eligibility for level of services and to improve the services we provide. The Centre offers therapeutic and support services to children with developmental disabilities and other special needs and their families. If you believe your child could benefit from any of The Centre's services, please complete this form and return it to the Centre. For service eligibility information, see The Centre's website at www.centreforchilddevelopment.ca or phone (604) 584-1361. Forward this completed form, by mail to The Centre for Child Development, 9460 140 St, Surrey, B.C. V3V 5Z4 or by FAX (604) 583-5113. Once we receive this form, we will contact you in writing for follow-up. The Centre is an equal opportunity service provider.

Child's Name _____ **Date of Birth** _____
First Last Month Day Year
(e.g. Jan / 29 / 2003)

BC Care Card Number _____ **Male** **Female**

Diagnosis _____

1. Parent/Guardian/Foster Parent Name _____ **Mother** **Father Other:** _____

Legal Guardian Yes No **Resides with child** Yes No

Address _____ **Postal Code** _____
City

Home Phone _____ **Cell Phone** _____ **Work Phone** _____

2. Parent/Guardian Name _____ **Mother** **Father Other:** _____

Legal Guardian Yes No **Resides with child** Yes No (If no please provide address)

Address/City _____ **Postal Code** _____

Home Phone _____ **Cell Phone** _____ **Work Phone** _____

3. Social Worker Name _____ **Phone** _____

Business Address _____ **Postal Code** _____

Legal Guardian Yes No

4. Additional Emergency
Contact not listed above _____ **Phone** _____

Name of school/preschool/daycare _____ **Phone** _____

Is your child involved with

1. Infant Development Program Yes No

2. Supported Child Development Program Yes No

If yes name of Consultant _____

Family Doctor _____ **Phone** _____

Address _____ **Postal Code** _____

Paediatrician _____ **Phone** _____

Address _____ **Postal Code** _____

Language(s) spoken at home _____

Do you need an interpreter? Yes No

Is this child an Aboriginal person, that is, North American Indian, Métis or Inuit (Eskimo)? Yes No

Child's race/ethnicity. Mark all that apply. (Optional)

Chinese

Filipino

Korean

South Asian

(East Indian, Pakistani, Sri Lankan, etc.)

White/Caucasian Other (specify) _____

Reason(s) for referral, concerns, or additional information (PLEASE ATTACH ANY MEDICAL OR DEVELOPMENTAL REPORTS IF AVAILABLE).

Services or consultations requested (if you require more information regarding the services below please see our website at www.centreforchilddevelopment.ca or phone (604) 584-1361).

- Eating Skills Team (interdisciplinary)** Dr's referral and Dr's report required
- Family Services** –Services provided along with other Centre services for a limited number of families.
- Fetal Alcohol Spectrum Disorder and Related Issues**
- Occupational Therapy**
- Physiotherapy**
- Psychology/Parent Support (Surrey/White Rock, birth to 12 years only** – Services provided along with other Centre services)
- Recreation Therapy**
- Speech-Language/Communication Therapy** (birth through school entry only)
- Supported Child Development**

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

Associated Professional(s) (assisting Legal Guardian to make referral)

Please Print Name: _____

Signature: _____ Phone Number: _____

Title, Relationship: _____ FAX #: _____

Legal Guardian (custodial parent, MCFD, other) making referral on behalf of child

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. The Centre reserves the right to require proof of guardianship or proof of change of guardianship at its discretion.

Print Name: _____ Signature: _____ Date: _____

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

Print Name: _____ Signature: _____ Date: _____

THE CENTRE FOR CHILD DEVELOPMENT
9460 – 140TH STREET, SURREY, BC V3V 5Z4 (604) 584-1361 FAX: (604) 583-5113

Please ensure all information is *completed* and *easy to read*. Incomplete forms will be returned to the parent/guardian for amendment. Witness must be at least 18 years of age.

CONSENT TO OBTAIN INFORMATION

Name of Child _____ (Print Name)

Child's Birthdate (Month/Day/Year) _____

I, the undersigned, do hereby authorize The Centre for Child Development to **OBTAIN** medical/educational information regarding my child from the following persons/agencies listed below.

[PLEASE INITIAL INSIDE EACH BOX YOU CHOOSE]:

<input type="checkbox"/>	Infant Development Program _____
<input type="checkbox"/>	Supported Child Development Program _____
<input type="checkbox"/>	Preschool/daycare/school _____
<input type="checkbox"/>	School District _____
<input type="checkbox"/>	Child's Doctor(s) (*Please list first and last names) _____

<input type="checkbox"/>	Surrey Memorial Hospital _____
<input type="checkbox"/>	BC Children's Hospital _____
<input type="checkbox"/>	Sunny Hill Health Centre _____
<input type="checkbox"/>	Orthotist _____
<input type="checkbox"/>	Foster Parent(s) _____
<input type="checkbox"/>	M.C.F D. Social Worker _____
<input type="checkbox"/>	Other Professionals involved with Child (please list) _____

CONSENT TO RELEASE INFORMATION

I also authorize The Centre for Child Development to **RELEASE** reports and verbally share medical/ educational information regarding my child with the persons/agencies listed below.

[PLEASE INITIAL INSIDE EACH BOX YOU CHOOSE]:

<input type="checkbox"/>	Infant Development Program _____
<input type="checkbox"/>	Supported Child Development Program _____
<input type="checkbox"/>	Preschool/daycare/school _____
<input type="checkbox"/>	School District _____
<input type="checkbox"/>	Child's Doctor(s) (*Please list first and last names) _____

<input type="checkbox"/>	Surrey Memorial Hospital _____
<input type="checkbox"/>	BC Children's Hospital _____
<input type="checkbox"/>	Sunny Hill Health Centre _____
<input type="checkbox"/>	Orthotist _____
<input type="checkbox"/>	Foster Parent(s) _____
<input type="checkbox"/>	M.C.F D. Social Worker _____
<input type="checkbox"/>	Other Professionals involved with Child (please list) _____

CENTRE REPORTS WILL BE SENT TO PARENT(S) AND/OR GUARDIAN IN ACCORDANCE WITH CENTRE POLICY

Name of Parent/Guardian authorized to give consent _____

Signature _____

Date _____

(Consent expires one (1) year from this date)

Name of Child (age 14 yrs or over) if appropriate
(Print Name) _____

Signature _____

Date _____

Please Note: The Centre reserves the right to require proof of guardianship or proof of change of guardianship at its discretion.