



DOGWOOD PLACE

Child and Youth Development Centre

Infant Development Program
Speech and Language Program

Occupational Therapy Program
Physiotherapy Program

FASD Key Worker
Supported Child Development Program

REFERRAL FORM

Date: _____

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

- Speech and Language Program (birth to school entry)
- Occupational Therapy Program (birth to school entry)
- Physiotherapy Program (birth to school entry)
- Feeding Consult (Occupational and Speech and Language Programs, birth to school entry)
- Infant Development Program (birth to 3 yrs.)
- Supported Child Development Program (birth to 12 yrs.)
- Fetal Alcohol Spectrum Disorder Key Worker (birth to 19 yrs.)

Does child qualify for Indigenous services? Yes No

Would parent/guardian prefer to be connected to Laichwiltach Family Life Society? Yes No

Name of Child: _____ Gender: _____

Date of Birth: _____ (Month/day/year) Age at referral: _____

Name of Legal Guardian(s): _____ Phone Number: _____

Name of parent/guardian _____ Email: _____

Phone: Home: _____ Work: _____ Cell: _____

Address: _____ City: _____ Postal Code: _____

Mailing Address (if different) _____ City: _____ Postal Code: _____

Name of parent/guardian _____ Email: _____

Phone: Home: _____ Work: _____ Cell: _____

Address: _____ City: _____ Postal Code: _____

Mailing Address (if different) _____ City: _____ Postal Code: _____

Family Physician: _____ Physician Phone Number: _____

Referral Source (Name or Agency): _____ If agency, contact name: _____

Referral Source address: _____ Phone number: _____

Reason for referral (please complete this section): _____

Does the parent/guardian agree with this referral and referral reason? Yes No

Is this child attending a child care centre? Yes No Waitlisted

Name of centre _____ Days and times attending: _____

C.C.: _____

