DOGWOOD PLACE

Child and Youth Development Centre

Child Parent Connections
Infant Development Program
Speech and Language Program
Occupational Therapy Program
Physiotherapy Program
Community Access Services
FASD Key Worker
Supported Child Development Program

REFERRAL FORM

Date: _____

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

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

Name of Child: _____ Gender: _____

B.C. Care Card-Personal Health Number:_____ Date of Birth: _____ Age at referral: _____
(Month/day/year)

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? ☐ Yes ☐ No

Would child qualify for Aboriginal services? ☐Yes ☐ No

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

Name of centre _____Days and times attending:_____

c.c.: _____ _____

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www.cradacl.bc.ca
Administered by the Campbell River and District Association for Community Living