DOGWOOD PLACE

Child and Youth Development Centre

SUPPORTED CHILD DEVELOPMENT PROGRAM
REFERRAL FORM TO REQUEST SUPPORT

Eligibility Criteria:
1. Children from birth to twelve years of age.
2. Have a developmental delay or disability in physical, cognitive, communicative or social/ emotional/behavioural areas
3. Need support in a regulated/licensed child care setting.

Name of Child: _____

Date of Birth: _____ ☐ **Female** ☐ **Male** **Age at Referral:** _____

☐ **Parent(s)** ☐ **Guardian(s)** _____

Address: _____ **Town:** _____ **Postal Code:** _____

Telephone: (Home): _____ **Optional :(Work) :** _____ **(Cell):** _____

Email (optional): _____

Reason for Referral; _____

_____

_____

This child requires additional support services in the following areas (specify):

☐ **Health care needs**
☐ **Assistance with gross motor skills**
☐ **Attention (ability to focus)**
☐ **Emotional development**
☐ **Eating**
☐ **Hearing**
☐ **Transitions**
☐ **Administration of medication**
☐ **Assistance with fine motor skills**
☐ **Communication**
☐ **Cognitive development**
☐ **Toileting**
☐ **Vision**
☐ **Other:** _____

Additional information: _____

_____

Child is attending child care centre ☐ **Yes** ☐ **No** ☐ **Waitlisted**

Name of centre: _____

Days and times attending: _____

Referral made by: (Print) _____ **Telephone:** _____

Address: _____

The parent/guardian is aware of, and approves the submission of this referral to Supported Child Development: ☐ **Yes** ☐ **No** **Comments:** _____

Signature: _____ **Date of Referral:** _____

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