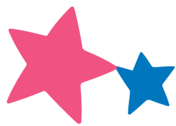

Fraser Valley **Child Development** Centre

REFERRAL FOR SERVICES

Has the parent or legal guardian consented to this referral? YES ☐ NO ☐

This referral will not be processed without parental/legal guardian consent.

The private and personal information collected on this form is used to determine eligibility and appropriateness of services to be provided. Identifying information (name, date of birth) may be shared with Public Health Speech and Language Program to avoid duplication of service.

CHILD'S LAST NAME, FIRST NAME	GENDER PRONOUN	DATE OF REFERRAL	DATE OF BIRTH (DD/MM/YYYY)
HOME ADDRESS			POSTAL CODE
MAILING ADDRESS (if different from above)			POSTAL CODE
ARE YOU COMFORTABLE COMMUNICATING IN ENGLISH? ☐YES ☐NO	PREFERRED LANGUAGE(S) SPOKEN AT HOME:	WOULD AN INTERPRETER BE HELPFUL? ☐YES ☐NO	PERSONAL HEALTH #
DOES YOUR CHILD IDENTIFY AS INDIGENOUS? ☐ YES ☐ NO	If yes, ☐ FIRST NATIONS ☐ MÉTIS ☐ INUIT	Referrals for children who are indigenous may be forwarded to Sto:lo IDP/SCD in Mission, Abbotsford or Chilliwack and to Seabird IDP/SCD in Fraser Cascade (with parent/guardian consent).	
PERSON(S) CHILD LIVES WITH (LEGAL GUARDIAN ☐ YES ☐ NO)	RELATIONSHIP TO CHILD	PHONE	E-MAIL ADDRESS
PERSON(S) CHILD LIVES WITH (LEGAL GUARDIAN ☐ YES ☐ NO)	RELATIONSHIP TO CHILD	PHONE	E-MAIL ADDRESS
HOME VISIT OR HEALTH/SAFETY CONCERNS ☐ YES ☐ NO (if yes, please specify)			
LEGAL GUARDIAN/SOCIAL WORKER NAME (if different than above)	E-MAIL ADDRESS		PHONE
ADDRESS	POSTAL CODE	AGENCY	FAX
NAME OF PRESCHOOL, DAYCARE, SCHOOL	CONTACT NAME		PHONE #
PHYSICIAN NAME:	PAEDIATRICIAN NAME:		
REASON FOR REFERRAL (e.g., small and large movements, daily living skills, communication, participating in home and community activities, social and emotional regulation).			
MEDICAL DIAGNOSIS ☐ YES ☐ NO (if yes, please specify)			
REFERRED BY (please print name)	PHONE	FAX	
RELATIONSHIP AND/OR FACILITY	ADDRESS/POSTAL CODE		
FORM COMPLETED BY	ORIGINAL DATE OF REFERRAL (DD/MM/YYYY)		

Revised May 26, 2022

Helping kids shine!