REFERRAL FORM

Early Intervention Program
Child Youth & Family Rehabilitation Services, Queen Alexandra Centre for Children's Health
2400 Arbutus Road, Victoria BC V8N 1V7 Tel: 250-519-5390 Fax: 250-519-6918

Reason for Referral:	Date of Referral:	
Referral Source:	Phone:	Fax:

Parent/Guardian is aware of this referral? ☐ YES ☐ NO
If NO, this referral cannot move forward.

Child Information (PLEASE PRINT)

CHILD'S FIRST NAME	CHILD'S LAST NAME	CARE CARD #	CHILD'S GENDER ☐ Female ☐ Male ☐ Other
DATE OF BIRTH (DD/MM/YYYY)	WOULD YOU FIND SERVICE DELIVERED BY A FIRST NATIONS OR METIS ORGANIZATION MORE CONSISTENT WITH YOUR PERSONAL BELIEFS? ☐ NO ☐ YES WHICH ONE?	CHILD RESIDES WITH: ☐ Both Parents ☐ Parent 1 only ☐ Parent 2 only ☐ Foster Family ☐ Other _____	

NAME OF PARENT OR GUARDIAN (FIRST AND LAST)
1.

ADDRESS	CITY	POSTAL CODE
TELEPHONE	CELL PHONE	EMAIL

NAME OF PARENT OR GUARDIAN (FIRST AND LAST)
2.

ADDRESS	CITY	POSTAL CODE
TELEPHONE	CELL PHONE	EMAIL

THE LEGAL GUARDIAN FOR THIS CHILD IS:

☐ Both Parents ☐ Parent 1 only ☐ Parent ☐ MCFD _____ (name, phone number) ☐ Other _____ (please specify)

If applicable – please provide a copy of any legal custody document regarding this child.

Additional Information (PLEASE PRINT)

PRIMARY LANGUAGE SPOKEN AT HOME	ARE YOU COMFORTABLE COMMUNICATING IN ENGLISH?
☐ English ☐ Other(s) Please list: _____	

Are you receiving or waiting for services from a community or private speech-language pathologist? NO ☐ YES ☐ NAME: _____

Are you receiving services from Victoria Native Friendship Centre? NO ☐ YES ☐ NAME(S): _____

Family Physician name: _____ Pediatrician name: _____

Does your child have a diagnosis? ☐ NO ☐ YES (please specify) _____

Other information pertinent to this referral: