REFERRAL FORM

3945 Matchette Rd.
Windsor, Ontario N9C 4C2
T: 519.252.7281
Toll Free: 1.800.976.JMCC (5622)
F: 519.252.5873
www.jmccentre.ca

☐ **PARENT / GUARDIAN / CLIENT HAS AGREED TO THIS REFERRAL (this box must be checked)**

CLIENT INFORMATION

Person Referred: _____ Date of Birth: _____
(First Name / Last Name) **(Month/Day/Year)**

Gender: ☐ Male ☐ Female ☐ Gender Neutral

Address: _____ City: _____ Postal Code: _____

Home Telephone: _____ Cell Phone: _____

Physician/Paediatrician: School or Child Care (if applicable):

CONTACT INFORMATION

Primary Contact: _____ Relationship to Client: _____

Address (*if different from above*): _____ City: _____ Postal Code: _____

Home Telephone: _____ Cell Phone: _____

E-mail (*for appointment reminders only*): _____

Secondary Contact: _____ Relationship to Client: _____

Address (*if different from above*): _____ City: _____ Postal Code: _____

Home Telephone: _____ Cell Phone: _____

E-mail (*for appointment reminders only*): _____

Client Lives With: ☐ Parents ☐ Mother ☐ Father ☐ Other: _____

Language(s) Spoken: Interpreter Required: ☐ Yes ☑ No

REASON FOR REFERRAL

OTHER AGENCIES INVOLVED

☐ None
☐ Children First ☐ Connections ☐ NICU ☐ CAS ☐ RCC Other:

SERVICES REQUESTED

☐ Occupational Therapy ☐ Physiotherapy ☐ Speech-Language Pathology
☐ Cleft Lip Palate/Craniofacial Dental Program ☐ VPI
☐ Augmentative Communication Clinic ☐ Seating & Mobility

REFERRAL SOURCE:

Place physician's stamp here ↓

Date: _____

OR

Name: _____
Agency/ Relationship: _____
Phone: _____
Date: _____