# \*Indicates mandatory field

\* **YES, Parent/Guardian/Client has agreed to this referral and sharing of this information.**

*By checking YES, you are stating that consent has been obtained from the Parent/Guardian/Client*

# CHILD/YOUTH INFORMATION:

|  |  |
| --- | --- |
| \*First Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Name:\_\_\_\_\_\_\_\_\_\_\_\_ \*Last Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **\***Date of Birth**:** (mm/dd/yyyy) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Age: \_\_\_\_\_\_\_\_\_\_\_\_  \*Gender  Female  Male  Other/Unknown | \*Address: Street:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Province:\_\_\_\_\_\_\_  Postal Code\_\_\_\_\_\_\_\_\_\_ |
| **Child/Youth lives with:** Both Parents  Mother  Father Shared Custody Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Does the child/youth attend school or daycare?**  School  Daycare  None Name of School or Daycare: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

# PARENT/GUARDIAN INFORMATION:

|  |  |
| --- | --- |
| \***Parent/Guardian 1: (Primary Contact)** First Name:\_\_\_\_\_\_\_\_\_\_\_ Last Name:\_\_\_\_\_\_\_\_\_\_\_\_\_Phone#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address: (if different than child’s) Street:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City:\_\_\_\_\_\_\_\_\_Province:\_\_\_\_\_Postal Code\_\_\_\_\_\_\_\_\_\_ | **\*Parent/Guardian 2: (Secondary Contact)** First Name:\_\_\_\_\_\_\_\_\_\_\_Last Name:\_\_\_\_\_\_\_\_\_\_\_\_Phone#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address: (if different than child’s) Street:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_Province:\_\_\_\_\_\_Postal Code\_\_\_\_\_\_\_\_\_ |
| \*REASON FOR REFERRAL Please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

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| Services Requested: (check all that apply) Augmentative Communication  Cleft Lip Palate/Craniofacial Dental Program  Occupational Therapy  Physiotherapy  Seating & Mobility  Speech & Language  Velopharyngeal Inadequacy (VPI) Clinic  Other, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Other Agencies Involved with Youth: (check all that apply)NoneChildren’s Aid SocietyChildren FirstConnections Early Years Family Centre/Talk 2 MeNICU (Neonatal Intensive Care Unit)Regional Children’s Centre/Hôtel-Dieu Grace HealthcarePrivate ProviderUnknownOther, please specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **The Smart Start Hub at JMCC** I would like a Navigator from the SmartStart Hub to conduct an exploratory assessment and help direct the family to appropriate services. | |

# ADDITIONAL INFORMATION:

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| --- | --- |
| **Is an interpreter needed:** Yes  No If ‘Yes’, please specify language: | |
| \*Person making the referral:First Name:\_\_\_\_\_\_\_\_\_\_\_Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \*Your relationship to child/youth:Parent/GuardianHealthcare/Community Provider |

# Send this form and reports to fax: 519-252-5873 “ATTN: Intake Dept” or by mail to the address above.