# \*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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |  |
| --- | --- |
| 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) [ ] None[ ] Children’s Aid Society[ ] Children First[ ] Connections Early Years Family Centre/Talk 2 Me[ ] NICU (Neonatal Intensive Care Unit)[ ] Regional Children’s Centre/Hôtel-Dieu Grace Healthcare[ ] Private Provider[ ] Unknown[ ] Other, 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:

|  |
| --- |
| **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/Guardian[ ] Healthcare/Community Provider  |

# Please attach and send in with this form any reports you wish to share with us.

# Send this form and reports to fax: 519-252-5873 “ATTN: Intake Dept”, or email to: referrals@jmccentre.ca.