Lansdowne Children's Centre

REFERRAL FORM

GC#:

PERSONAL DATA:			
CHILD'S NAME:		DATE:	
DATE OF BIRTH:		GENDER:	
ADDRESS:		CITY:	
COUNTY:		POSTAL CODE:	

CONTACT NAME	Same Last Name?	PHONE NUMBER / EMAIL	
MOTHER:			
		Email	
FATHER:			
		Email	
GUARDIAN (if not parent): Relationship:			
		Email	

DIAGNOSIS/REASON FOR REFERRAL:

REFERRAL FORM

REFERRED FOR:			
PHYSIOTHERAPY		SPECIAL SERVICES AT HOME	
OCCUPATIONAL THERAPY		RESPITE CARE	
SPEECH THERAPY		EVERY KID COUNTS	
SOCIAL WORK (referral can only be made with referral for another service)		AUTISM SPECTRUM DISORDER RESPITE	
AUTISM SERVICES (Purchase ABA)		KIDS COUNTRY INN	
AUTISM SERVICES (Ministry Funded)		OAP REGISTRATION #:	
CHILD DEVELOPMENT PROGRAM		School:	
EARLY INTEGRATION PROGRAM		Child Care:	

REFERRAL INITIATED BY:			
NAME:		POSITION:	
EMAIL:		PHONE:	

OFFICE USE ONLY					
Email Consent:		Enews Consent:		COMPRIV:	

You should receive confirmation of this referral within 5 business days.
If not please call Central Intake at 519-753-3153 x 206 to ensure receipt of the referral.