REQUEST FOR SERVICE FOR INFANTS TO SCHOOL AGE

Date of Request: _____

Personal Information (child being referred)				
First Name:	**Last Name:**		**Middle Name:**	**Date of Birth:** (mm/dd/yyyy)
Address (including mailing address)**:**			**Sex:** ☐ Male ☐ Female	**Diagnosis:**
City:	**County:** **S** ☐ **D** ☐ **G** ☐	**Postal Code:**	**Home Telephone #:**	**Other Telephone #** (specify)**:**
*	***IMPORTANT*:** **TWO DOCUMENTS REQUIRED AS PROOF OF CHILD'S RESIDENCY BEFORE REFERRAL CAN BE PROCESSED (TWO MOST RECENT UTILITY BILLS, ETC.).**			*

Referring Agent (individual making the referral)	
Agent's Name:	**Agency or Relationship:**
Full Address:	**Telephone Number:**

Reason for Referral (What seems to be the problem/Purpose of referral)

Why are you referring this child to our Centre? What is the nature of the problem, specifically? _____

_____

CENTRE'S PROGRAMS	SERVICES BEING REQUESTED
Occupational Therapy (0 – 5)	☐Assessment (0 - 5) ☐Consultation (0 - 5) ☐Equipment Prescription (0 - 5) ☐Treatment and Programming (0 – 5)
Children Services (0 – 18)	☐Infant Development (0 – 6) ☐Case Management (0 – 18) ☐Functional Developmental Assessment (0 – 6)
Clinical Services	☐Psychological Assessment ☐Consultation ☐Counselling
Family Relief Program for Developmentally Challenged Children and Adults	☐Centre's Respite Home
Family Relief Program for Physically Handicapped Children (0 – 18)	☐In-Home Respite Funding (0 – 18)
Out-of-Home Respite Initiative for Medically Fragile and Technologically Dependent Children (0 – 18)	☐Centre's Respite Home ☐Recreational Respite Funding (0 – 18)
Independent Respite Services	☐In-Home Respite Funding
Autism Spectrum Disorder Respite Funding (0 – 18)	☐ASD Funding (0 – 18)

I M P O R T A N T

In order to process your referral in a timely manner, this referral form must be completed and returned within two months, otherwise, it will be assumed that our services are no longer required. Include documentation that will assist us such as past psychological assessments, developmental assessments, medical records, and all pertinent information regarding developmental needs of the child being referred.

S.D.&G. DEVELOPMENTAL SERVICES CENTRE
775 Campbell Street, Cornwall ON K6H 7B7
Tel.: (613) 937-3072 1-800-267-1724 Fax: (613) 937-4550 www.developmentalservices.ca

Next of Kin (Parent/Guardian, etc.)			
Name:			**Specify relation to child:** _____ ☐Biological ☐Step ☐Adoptive ☐Guardian
Address (including mailing address)**:** Same as Child Being Referred☐			
City:	**Postal Code:**	**Telephone Number** (home)**:**	**Telephone Number (**work)**:**
Name:			**Specify relation to child:** _____ ☐Biological ☐Step ☐Adoptive ☐Guardian
Address (including mailing address)**:** Same as Child Being Referred☐			
City:	**Postal Code:**	**Telephone Number** (home)**:**	**Telephone Number** (work)**:**

Foster Parents' Information (if applicable)			
Name of Foster Parent(s):		**Agreement:** ☐Temporary ☐Crown ☐Supervision Order ☐Monitoring ☐Special Needs	**In Care Since**
Address (including mailing address)**:** **Same as Child Referred** ☐		**Home Number:**	**Work Number:**
City:	**Postal Code:**	**NAME OF CONTACT PERSON AT CAS:**	

Custody/Agreement Status (if applicable)
Who has legal custody of the child being referred? ☐Mother ☐Father ☐Joint ☐Other (name) _____ Agency or Relationship _____ Visitation Rights: ☐No ☐Yes If yes, ☐Supervised ☐Unsupervised Who? _____ When? _____

Employment History of Parent(s)
Is (are) parent(s) currently employed? ☐No ☐Yes If yes, please indicate where? Mother _____ Father _____

Parent(s) Education	
Mother's Date of Birth:_____ Grade Level Attained:_____ Type of Classes:_____	Father's Date of Birth:_____ Grade Level Attained:_____ Type of Classes:_____

Sibling History (if applicable)			
NAME OF SIBLING(S)			
DATE OF BIRTH			
PROBLEM/ACHIEVEMENT			

Language			
What language do you prefer receiving your services in?		□English	□French
What language is spoken in the home?	□English only □French only □Both □Other _____		
□**Mother** □**Foster Mother**	**Mother Tongue** (English)□ (French)□ _____ (Other)□	□**Mother** □**Foster Mother**	**Second Language** (English)□ (French)□ _____ (Other)□
□**Father** □**Foster Father**	**Mother Tongue** (English)□ (French)□ _____ (Other)□	□**Father** □**Foster Father**	**Second Language** (English)□ (French)□ _____ (Other)□
Child Referred	**Mother Tongue** (English)□ (French)□ _____ (Other)□	**Child Referred**	**Second Language** (English)□ (French)□ _____ (Other)□
Correspondence and Documentation Preference:		□English	□French

Is the child being referred currently involved with any other services and/or currently waiting to receive any other services? (day care, school, therapies, healthy babies/healthy children's program, etc.)

PRESENTLY RECEIVING			**WAITING LIST**	
Organization	*Name*	*Service*	*Organization*	*Service*

Has the child being referred received any types of service in the past? □Speech □Physio □OT □ Psych

<u>Pertinent Documentation to Obtain in Determining Eligibility for our Services</u>:

Formal Assessment (speech therapy, occupational therapy, physio therapy, psychological) □No □Yes

If yes, Name of Agency:_____ Date:_____

Others (Medical Records) □No □Yes

If yes, Name:_____ Date:_____

Were there any complications during the pregnancy or the delivery? □No □Yes

_____

_____

Premature □No □Yes

Low Birth Weight □No □Yes _____ pounds ___ _____ounces

UNDER 18 MONTHS OF AGE

(Please indicate any concerns you may have had if child is older than 18 months at the bottom of the page and/or answer the questions below)

Language	
Does your child babble or make cooing sounds?	☐No ☐Yes
What words can your child say? (Mama, Dada, dodo, bye, car, shoes, juice)	☐No ☐Yes
Can your child respond to his name?	☐No ☐Yes
Can your child follow simple instructions such as pick up your toys, go get your shoes?	☐No ☐Yes

Gross Motor		
Can your child sit with no support?	When?	☐No ☐Yes
Can your child roll over?	When?	☐No ☐Yes
Can your child crawl?	When?	☐No ☐Yes
Can your child stand holding onto furniture?		☐No ☐Yes
Can your child stand alone?		☐No ☐Yes
Can your child walk?		☐No ☐Yes

Fine Motor	
Can your child pick up a small object?	☐No ☐Yes
Can your child point to an object when he/she wants something?	☐No ☐Yes
Can your child reach for an object that he/she wants?	☐No ☐Yes
Can your child scribble?	☐No ☐Yes
Can your child bring his/her hands together such as clapping hands, banging two objects together?	☐No ☐Yes
Can your child fill and empty a large container?	☐No ☐Yes

Personal – Social	
Can your child smile spontaneously?	☐No ☐Yes
Can your child play pat-a-cake?	☐No ☐Yes
Can your child wave bye-bye?	☐No ☐Yes
Can your child drink from a cup?	☐No ☐Yes
Can your child use a spoon or a fork?	☐No ☐Yes
Can your child remove his clothing?	☐No ☐Yes

Other	
Can your child track/follow an object or a person?	☐No ☐Yes
Can your child imitate a simple activity such as imitating you brushing your teeth?	☐No ☐Yes

OVER 18 MONTHS TO SCHOOL ENTRY

Language	
Can your child speak clear words?	☐No ☐Yes
Can your child combine words? (How many?) 1 word 2 words 3 words Full sentences	☐No ☐Yes
Can other people understand what your child is saying?	☐No ☐Yes
Can your child follow a sequence of two instructions such as pick up your toy and come for supper?	☐No ☐Yes
Can your child sit and watch a short television program?	☐No ☐Yes
Can your child sit through a story being read?	☐No ☐Yes
Does your child know the main body parts?	☐No ☐Yes
Can your child recite rhymes, songs?	☐No ☐Yes

Colours/Numbers/Letters/Shapes	
Does your child know the basic four colours? (blue, red, yellow, green) or more?	☐No ☐Yes
Can your child count to 10? What number can your child count to?	☐No ☐Yes
Does your child know the ABCs?	☐No ☐Yes
Does your child know the three main shapes? Square ☐ Triangle ☐ Circle☐	☐No ☐Yes

Gross Motor	
Can your child walk up and down the stairs by alternating feet?	☐No ☐Yes
Can your child jump over a small object such as a small toy, a hair brush?	☐No ☐Yes
Can your child kick a ball?	☐No ☐Yes
Can your child throw a ball?	☐No ☐Yes
Can your child catch a ball?	☐No ☐Yes

Fine Motor	
Can your child build a tower of 2 cubes, 4 cubes, 6 cubes, 8 cubes?	☐No ☐Yes
Can your child copy a horizontal line, vertical line, a circle, a square or simple shapes?	☐No ☐Yes
Can your child cut with a pair of scissors?	☐No ☐Yes
Can your child complete a simple four-piece indented wooden peg puzzle?	☐No ☐Yes

Personal – Social	
Is your child fully toilet trained during the day? (Urinating and bowel movements)	☐No ☐Yes
Is your child fully trained at night? (Urinating and bowel movements)	☐No ☐Yes
Can your child help around the house? (Pick up toys – cleaning)	☐No ☐Yes
Can your child brush his/her teeth?	☐No ☐Yes
Can your child wash and dry his/her hands?	☐No ☐Yes
Can your child dress himself/herself?	☐No ☐Yes
Can your child pretend-play such as play house, tea party?	☐No ☐Yes

Physical Problems	
Hearing Checked ☐No ☐Yes	Vision Checked ☐No ☐Yes
Outcome	**Outcome**

Medical Professionals (Family Doctor, Pediatrician, Specialist, Psychiatrist, etc.)	
Name: Specialty: Address: Telephone Number:	Name: Specialty: Address: Telephone:
Name: Specialty: Address: Telephone Number:	Name: Specialty: Address: Telephone:

MEDICATIONS (if applicable)		
Name of Medication	*Dosage*	*Reason*
Who prescribes the medication?		

Consent Section		
Do you consent to services?	☐No	☐Yes
Are you giving us permission to inform the referring agent (when applicable) about the status of the referral?	☐No	☐Yes
Signature of Parent(s)Guardian: _____ **Date:** _____		

COMMENTS (Please include any behavioural concerns, observations, or any other pertinent information, etc.):

_____

_____

_____

_____

_____