

## REQUEST FOR SERVICE FOR SCHOOL AGE CHILDREN

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: <input type="checkbox"/> Male <input type="checkbox"/> Female	Diagnosis:	
City:	County: S <input type="checkbox"/> D <input type="checkbox"/> G <input type="checkbox"/>	Postal Code:	Home Telephone #:	Other Telephone # (specify):	
<b>*</b>	<b><u>IMPORTANT:</u></b> <b><u>TWO DOCUMENTS REQUIRED AS PROOF OF CHILD'S RESIDENCY BEFORE REFERRAL CAN BE PROCESSED (TWO MOST RECENT UTILITY BILLS, ETC.).</u></b>				<b>*</b>

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

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
Children Services (0 – 18)	<input type="checkbox"/> Infant Development (0 – 6) <input type="checkbox"/> Case Management (0 – 18) <input type="checkbox"/> Functional Developmental Assessment (0 – 6)
Clinical Services	<input type="checkbox"/> Psychological Assessment <input type="checkbox"/> Consultation <input type="checkbox"/> Counselling
Family Relief Program for Developmentally Challenged Children and Adults	<input type="checkbox"/> Centre's Respite Home
Family Relief Program for Physically Handicapped Children (0 – 18)	<input type="checkbox"/> In-Home Respite Funding (0 – 18)
Out-of-Home Respite Initiative for Medically Fragile and Technologically Dependent Children (0 – 18)	<input type="checkbox"/> Centre's Respite Home <input type="checkbox"/> Recreational Respite Funding (0 – 18)
Independent Respite Services	<input type="checkbox"/> In-Home Respite Funding
Autism Spectrum Disorder Respite Funding (0 – 18)	<input type="checkbox"/> ASD Respite Funding (0 – 18)

### IMPORTANT

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 or psycho-educational assessments, psychiatric assessments, report cards/transcript, individual educational plan(s), individual placement and review committee report(s), medical records, and all pertinent information regarding developmental needs of the person 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](http://www.developmentalservices.ca)

Next of Kin (Parent/Guardian, etc.)			
<b>Name:</b>			<b>Specify relation to individual:</b> _____ <input type="checkbox"/> Biological <input type="checkbox"/> Step <input type="checkbox"/> Adoptive <input type="checkbox"/> Guardian
<b>Address (including mailing address):</b> Same as Child Being Referred <input type="checkbox"/>			
<b>City:</b>	<b>Postal Code:</b>	<b>Home Number:</b>	<b>Work Number:</b>
<b>Name:</b>			<b>Specify relation to individual:</b> _____ <input type="checkbox"/> Biological <input type="checkbox"/> Step <input type="checkbox"/> Adoptive <input type="checkbox"/> Guardian
<b>Address (including mailing address):</b> Same as Child Being Referred <input type="checkbox"/>			
<b>City:</b>	<b>Postal Code:</b>	<b>Home Number:</b>	<b>Work Number:</b>

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

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

Employment History of Parent(s) (if applicable)	
<b>Is (are) parent(s) currently employed?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes      If yes, please indicate where?	
Mother _____	Father _____

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

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

### 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 \_\_\_\_\_

<input type="checkbox"/> Mother <input type="checkbox"/> Foster Mother	Mother Tongue (English) <input type="checkbox"/> (French) <input type="checkbox"/> (Other) <input type="checkbox"/>	<input type="checkbox"/> Mother <input type="checkbox"/> Foster Mother	Second Language (English) <input type="checkbox"/> (French) <input type="checkbox"/> (Other) <input type="checkbox"/>
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<input type="checkbox"/> Father <input type="checkbox"/> Foster Father	Mother Tongue (English) <input type="checkbox"/> (French) <input type="checkbox"/> (Other) <input type="checkbox"/>	<input type="checkbox"/> Father <input type="checkbox"/> Foster Father	Second Language (English) <input type="checkbox"/> (French) <input type="checkbox"/> (Other) <input type="checkbox"/>
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Child Referred	Mother Tongue (English) <input type="checkbox"/> (French) <input type="checkbox"/> (Other) <input type="checkbox"/>	Child Referred	Second Language (English) <input type="checkbox"/> (French) <input type="checkbox"/> (Other) <input type="checkbox"/>
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Correspondence and Documentation Preference: English French

### \* \* \* VERY IMPORTANT \* \* \*

#### School History — complete names and locations of all schools attended

Name of Present School:	Current Grade Level:	<u>Type of Program:</u> <input type="checkbox"/> 50/50 <input type="checkbox"/> Immersion <input type="checkbox"/> Core <input type="checkbox"/> Living & Learning <input type="checkbox"/> Co-op <input type="checkbox"/> Resource Assistance <input type="checkbox"/> Special Education <input type="checkbox"/> _____
Name of Previous School:	Grades attended: From _____ To _____	<u>Type of Program:</u> <input type="checkbox"/> 50/50 <input type="checkbox"/> Immersion <input type="checkbox"/> Core <input type="checkbox"/> Living & Learning <input type="checkbox"/> Co-op <input type="checkbox"/> Resource Assistance <input type="checkbox"/> Special Education <input type="checkbox"/> _____
Name of Previous School:	Grades attended: From _____ To _____	<u>Type of Program:</u> <input type="checkbox"/> 50/50 <input type="checkbox"/> Immersion <input type="checkbox"/> Core <input type="checkbox"/> Living & Learning <input type="checkbox"/> Co-op <input type="checkbox"/> Resource Assistance <input type="checkbox"/> Special Education <input type="checkbox"/> _____
Name of Previous School:	Grades attended: From _____ To _____	<u>Type of Program:</u> <input type="checkbox"/> 50/50 <input type="checkbox"/> Immersion <input type="checkbox"/> Core <input type="checkbox"/> Living & Learning <input type="checkbox"/> Co-op <input type="checkbox"/> Resource Assistance <input type="checkbox"/> Special Education <input type="checkbox"/> _____
Identification Placement & Review Committee Completed (IPRC): <input type="checkbox"/> No <input type="checkbox"/> Yes	Individual Education Plan Completed (IEP): <input type="checkbox"/> No <input type="checkbox"/> Yes	

Did the individual being referred repeat any grades? (if applicable)

## UNDER 18 MONTHS OF AGE

(Please indicate any concerns you may have had at the bottom of the page and/or answer the questions below)

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

Gross Motor	
Can your child sit with no support?	When? <input type="checkbox"/> No <input type="checkbox"/> Yes
Can your child roll over?	When? <input type="checkbox"/> No <input type="checkbox"/> Yes
Can your child crawl?	When? <input type="checkbox"/> No <input type="checkbox"/> Yes
Can your child stand holding onto furniture?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Can your child stand alone?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Can your child walk?	<input type="checkbox"/> No <input type="checkbox"/> Yes

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

Personal – Social	
Can your child smile spontaneously?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Can your child play pat-a-cake?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Can your child wave bye-bye?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Can your child drink from a cup?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Can your child use a spoon or a fork?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Can your child remove his clothing?	<input type="checkbox"/> No <input type="checkbox"/> Yes

Other	
Can your child track/follow an object or a person?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Can your child imitate a simple activity such as imitating you brushing your teeth?	<input type="checkbox"/> No <input type="checkbox"/> Yes

## OVER 18 MONTHS TO SCHOOL ENTRY

(Please indicate any concerns you may have had anywhere on this sheet and/or answer the questions below)

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

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

<b>Gross Motor</b>	
Can your child walk up and down the stairs by alternating feet?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Can your child jump over a small object such as a small toy, a hair brush?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Can your child kick a ball?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Can your child throw a ball?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Can your child catch a ball?	<input type="checkbox"/> No <input type="checkbox"/> Yes

<b>Fine Motor</b>	
Can your child build a tower of 2 cubes, 4 cubes, 6 cubes, 8 cubes?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Can your child copy a horizontal line, vertical line, a circle, a square or simple shapes?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Can your child cut with a pair of scissors?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Can your child complete a simple four-piece indented wooden peg puzzle?	<input type="checkbox"/> No <input type="checkbox"/> Yes

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

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

PRESENTLY RECEIVING			WAITING LIST	
<i>Organization</i>	<i>Name</i>	<i>Service</i>	<i>Organization</i>	<i>Service</i>

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

**Pertinent Documentation to Obtain in Determining Eligibility for our Services:**

**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

Physical Problems	
Hearing Checked <input type="checkbox"/> No <input type="checkbox"/> Yes	Vision Checked <input type="checkbox"/> No <input type="checkbox"/> Yes
<b>Outcome</b>	<b>Outcome</b>

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:

