Referral form for Niagara Children's Centre/Speech Services Niagara

DATE OF REFERRAL REQUEST: _____

CLIENT INFORMATION

*Please note any legal guardian may consent to referral.
Consent received: ☐ Yes ☐ No If no, referral will not be processed.
*Please share if child has received service from us in the past. ☐ No ☐ Yes Specify _____
*Please note family must reside in catchment area to receive service.

Child's Name: _____
Last First Middle

Date of Birth: ____ ____ _____ Gender: ☐ M ☐ F
mm dd yyyy

Address:

_____ _____ _____ _____ _____
Unit# Street # Street Name City Postal Code

Language(s) spoken in the home: _____
Child's 1st Language: _____ Service Language Options: English / French

Legal Guardian: ____ Both Parents ____ Parent # 1 only ____ Parent #2 only
____ FACS ____ Other family situation _____
*If primary contact is FACS please add name and number of worker:
_____

Legal Guardian/ Parent #1 (full name): _____ Parent#1 phone #:_____
Alternate #: _____ Email:_____

Legal Guardian/ Parent #2 (full name): _____ Parent #2 Phone #:_____
Alternate #: _____ Email:_____

Physician/Pediatrician: _____

School/Childcare: _____ # of days _____a.m. p.m.

Other Community Agencies Involved (or child is on waiting list): ☐ No ☐ Yes If yes, identify the service(s):
___ Hotel Dieu Shaver Health and Rehabilitation Centre (HDS) / Audiology
___ Community Living/ Niagara Support Services – Specify _____
___ Bethesda (Autism Services/ CDAS)
___ Family and Children's Services (FACS) Specify _____
___ Hospital for Sick Children
___ McMaster Children's Hospital
___ Infant & Child Development Services /Healthy Babies/Healthy Children (Niagara Region)
___ Pathstone Mental Health Services
___ OTHER: _____

Family history of speech or language delays or developmental delays? ☐ No ☐ Yes If yes, specify _____
_____

Anything out of the ordinary with your pregnancy or delivery? ☐ No ☐ Yes If yes, specify _____
_____

Any other major illnesses or diagnoses? ☐ No ☐ Yes If yes, identify _____

Any allergies? ☐ No ☐ Yes If yes, specify _____

Any medications? ☐ No ☐ Yes If yes, specify _____

Immunizations up to date? ☐ Yes ☐ No If no, specify _____

Transportation Issues: _____

Anything else we need to know to serve you better in regards to religious or cultural practices? ☐ No ☐ Yes
If yes, specify _____

Concerns by: Parent Legal Guardian Teacher/School Other: _____

Identified Issues / Areas of concern: _____

_____

_____

_____

Referral Source:
☐ Parent/Legal Guardian ☐ Medical ☐ Community Agency ☐ Other _____

Referral Source Name and Contact Information: _____

Consent Source: Family and Children's Services Parent #1 Parent #2 Legal Guardian

Parent/ Legal Guardian Name (please PRINT full name) _____

Parent/ Legal Guardian Signature_____

Interpreter Required? ☐ N ☐ Y If yes, language needed? _____

567 Glenridge Avenue, St. Catharines, ON L2T 4C2 | Tel: 905-688-1890 ext 110 Fax: 905-688-9181
www.niagarachildrenscentre.com | www.speechservicesniagara.ca

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CONSENT FOR SHARING of INFORMATION

I , _____ agree
(Name of parent / guardian)
that Speech Services Niagara can share information between other care providers. These professionals are initialed by me, below. This is to help in the care of my child,

_____
(Name of client) (Date of Birth)

initial	
____	**Physician(s)** _____
____	**Regional Municipality of Niagara** (Public Health Department / Infant and Child Development Services)
____	**Pathstone Mental Health Services**
____	**Childcare Centre** _____
____	**Children's Aid Society Niagara** (FACS) _____
____	**Community Care Access Centre – Niagara**
____	**District School Board of Niagara**
____	**Niagara Catholic District School Board**
____	**Conseil scolaire Viamonde**
____	**Conseil scolaire catholique MonAvenir**
____	**Hotel Dieu Shaver Rehab**
____	**Other** _____

Speech Services Niagara is a partnership between Niagara Children's Centre and the Niagara Health System so a file with typical/common health information on my child may be located at any of these sites. An electronic consent is also kept on file. I understand that I can change my mind and change this consent at any time.

_____ _____
Signature of parent / guardian Date

_____ _____
Signature of witness Date

_____
Address and telephone number of witness / organization (if signed off-site)