



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	Fi	rst	Middle	
	Gend dd yyyy	er: M M	F		
Unit# Street #	Street Name		City	Postal Code	
Language(s) spoken in the home: Child's 1st Language: Service Language Options: English / French Legal Guardian: FACS Other family situation *If primary contact is FACS please add name and number of worker:					
Legal Guardian/ Pa Alternate #:	rent #1 (full name):	Email:	Parent#1 phone	#:	
			Parent #2 Phone		
Physician/Pediatric	cian:				
			# of da	aysa.m. p.m.	
Hotel Dieu Sha Community Liv Bethesda (Aut Family and Chi Hospital for Sia McMaster Chil Infant & Child Pathstone Mei	aver Health and Rehabili ving/ Niagara Support Se ism Services/ CDAS) ildren's Services (FACS) S ck Children Idren's Hospital	tation Centre (ervices – Specif Specify 'Healthy Babies	s/Healthy Children (Niagara R		

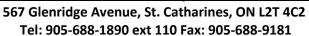
Family history of speech or language delays or developmental delays? No Yes If yes, specify
Anything out of the ordinary with your pregnancy or delivery? No Yes If yes, specify
Any other major illnesses or diagnoses? No Yes If yes, identify
Any allergies? No Yes If yes, specify
Any medications? No Yes 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
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



Niagara Children's Centre / Speech Services Niagara





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CONSENT FOR SHARING of INFORMATION

that Speec	h Services Niagara can share infor	agree t / guardian) mation between other care providers. This is to help in the care of my child,			
(Nam	e of client)	(Date of Birth)			
initial	Physician(s)Regional Municipality of Niagara	(Public Health Department / Infant and Chile			
_	Development Services) Pathstone Mental Health Services Childcare Centre				
_	Children's Aid Society Niagara (FACS) Community Care Access Centre – Niagara				
<u> </u>	District School Board of Niagara Niagara Catholic District School Board Conseil scolaire Viamonde				
_	Conseil scolaire catholique MonAven Hotel Dieu Shaver Rehab Other	ir			
Niagara He be located a	vices Niagara is a partnership betv alth System so a file with typical/co	veen Niagara Children's Centre and the mmon health information on my child may consent is also kept on file. I understand			
Signature of parent / guardian		Date			
Signature of witness		Date			
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