



## REFERRAL / APPLICATION FORM

Please complete this form in full. Include all documents that will support this application for service. This may include reports from Doctors, Speech and Language Pathologists, Occupational and Physical Therapists, IDP consultants, Health Nurses and Child Care Professionals or other SCDP Consultants. If you are unsure about what to include, you can contact the SCD program for further information by calling 604 998-0131 to ask the Coordinator.

### FAMILY AND CHILD INFORMATION:

Child's Last Name:	Child's First Name:	Middle Name:
<b>Medical Health Number</b>	Female <input type="checkbox"/> Male <input type="checkbox"/>	Date of Birth:
Home Address:	Postal Code:	Home Phone Number:
City:	Province:	

Parent / Guardian:	Relationship:	Work/Cell Number
Home Address:	Postal Code:	Phone Number
City:	Province	
Parent / Guardian:	Relationship:	Work/Cell Number
Home Address:	Postal Code:	Phone Number
City:	Province:	

Siblings:	Sex:	Date of Birth:
	Male <input type="checkbox"/> Female <input type="checkbox"/>	
	Male <input type="checkbox"/> Female <input type="checkbox"/>	
	Male <input type="checkbox"/> Female <input type="checkbox"/>	

Are you a Canadian Citizen?    Yes <input type="checkbox"/> No <input type="checkbox"/>	If NO, what is your status?
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How would you like us to contact you?     by phone     by fax     by letter     by email \_\_\_\_\_

First Language Spoken at Home: \_\_\_\_\_ Interpreter Needed? Yes / No

MCFD would like to be able to have accurate information to plan future funding.  
If desired, please self-identify your aboriginal status.    Yes / No (circle one)

# SUPPORTED CHILD DEVELOPMENT REFERRAL/APPLICATION FORM

Is your child on any medication? (please list) \_\_\_\_\_

Why are you requesting Supported Child Development? (reason for referral; child's needs and/or diagnosis): \_\_\_\_\_

Please give a brief description of your child's abilities, needs, personality, behaviour and/or any other information you want to tell us about your child:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**CHILD CARE INFORMATION:**

**Current** Child Care Setting: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

Contact Name: \_\_\_\_\_ When did your child start at this program? \_\_\_\_\_

Days of the week & hours of the day that your child attends child care: \_\_\_\_\_

**Previous** Child Care Setting: \_\_\_\_\_

Were supports required: Yes  No

If yes, what type(s) of support:  **SCDP Consultant**  **Shared extra staffing**  **Individual extra staffing**

**If not enrolled** in child care, type of child care program preferred: Preschool \_\_\_\_\_ Group Day care \_\_\_\_\_  
Family Child Care \_\_\_\_\_ Out of School Care \_\_\_\_\_

Name of child care program you have in mind (if applicable): \_\_\_\_\_

How will you take your child to child care?  by car  on the bus  walk  other: \_\_\_\_\_

**For out-of school care program, please complete:**

Child's School:	Grade:	Phone:
Teacher's Name:	School Contact:	

**OTHER SERVICES INFORMATION**

Please provide some information on other services, including doctors and other professionals, involved with your child / family:

Name of Service Provider	Agency Name	Phone #	Assessments Done (if applicable)	Consent (Initial)

# SUPPORTED CHILD DEVELOPMENT REFERRAL/APPLICATION FORM

ASSESSMENT DOCUMENTS, IF AVAILABLE, ARE NEEDED TO ASSIST WITH DETERMINING YOUR CHILD'S ELIGIBILITY FOR SUPPORTED CHILD CARE.

PLEASE PROVIDE CONSENT BELOW TO INCLUDE DOCUMENTS WITH THIS REFERRAL FORM.

### Consent:

I give permission to release this referral form, and supporting documentation from those service providers I have initialed above, to:

North Shore Supported Child Development Program Yes  No  (please initial)

Child Care Program(s) including \_\_\_\_\_ Yes  No  (please initial)  
(name(s) of child care programs)

\_\_\_\_\_  
Parent / Guardian Signature Date

### REFERRAL SOURCE INFORMATION:

Name of Person Making Referral and/or Assisting Family with Referral: \_\_\_\_\_

Referral Source Organization (if not the family): \_\_\_\_\_

Phone Number: \_\_\_\_\_

I give permission to obtain written and verbal information regarding my child from this referral source (where this is not the family):

North Shore Supported Child Development Program Yes  No  (please initial)

\_\_\_\_\_  
Parent / Guardian Signature Date

\_\_\_\_\_  
Signature of Witness to Referral Form Date

### FOR INTERNAL USE ONLY

Date Referral Received: \_\_\_\_\_ Referral Received By: \_\_\_\_\_

Designated SCD Consultant /Intake Consultant: \_\_\_\_\_