New Westminster Children's Centre

REFERRAL FORM

Send completed forms to:
811 Royal Avenue, New Westminster, BC V3M 1K1
Phone: 604-521-8078 Fax: 604-521-8074

Please initial to indicate that you have spoken to the family and they consent to this referral: _____

*For children referred for Speech Language Therapy: NWCC intake worker will share the child's name with Fraser Health to avoid duplication of services

PLEASE CHECK ALL THAT APPLY: Date of Referral_____
Month/Day/Year

- ❑ Physical Therapy *(birth to kindergarten entry)*
- ❑ Speech-Language Therapy *(birth to kindergarten entry)*
- ❑ Occupational Therapy *(birth to kindergarten entry)*
- ❑ Supported Child Development *(birth to 19 years)*
- ❑ Key Worker Services *(birth to 19 years)*
- ❑ Infant Development Program *(birth to 3 years)*

Is this child eligible for Aboriginal programs? ❑ Yes ❑ No

Reason for Referral: _____

_____

_____

Name of Referral source: _____ Contact #: _____

Child's Name: _____ M F DOB**:** _____ CCA: _____
Month/Day/Year

Parent Name: _____ Contact #: _____ Alt#: _____

Address: _____

Email: _____

Parent Name: _____ Contact #: _____ Alt#: _____

Address if different: _____

Email: _____

If in foster care: Name of Legal Guardian: _____ Contact #: _____

Address: _____

Language spoken in the home: _____ Is an interpreter needed? ❑ Yes ❑ No

Family Doctor and/or Specialist Name: _____ Contact #: _____

If in Child Care or Preschool:

Name of Child Care Program: _____ Contact #: _____

For Office Use Only

Date Received: _____ Referral Taken By: _____

Referral Status W = waitlist A = active service; if A, put initials of staff person involved	IDP	SCD	KW	SLP	PT	OT

Updated Jan 2014