



Child Development Centre
of Prince George and District
1687 Strathcona Avenue, Prince George, BC V2L 4E7
Phone: (250) 563-7168 Fax: (250) 563-8039

Request for Services

northern health
Speech & Language Clinic
1444 Edmonton Street, Prince George, BC V2M 6W5
Phone: (250) 565-7370 Fax: (250) 565-7386

Child's Name: _____ D.O.B: _____ Gender: M/F
First Name, Last Name Month/Day/Year

PHN#: _____ English: Other: _____ Interpreter Needed: Y/N Aboriginal: Y /N (for MCFD Statistics)

Legal Guardian: _____ (_____) Phone: _____
First Name, Last Name (Relationship) home cell work

Address: _____
Address City Province Postal Code

Legal Guardian 2: _____ (M, F, SW, FP) Phone: _____
First Name, Last Name (Relationship) home cell work

Address: _____
Address City Province Postal Code

Email: _____

Other: _____ (M, F, SW, FP) Phone: _____
First Name, Last Name (Relationship) home cell work

Address: _____
Address City Province Postal Code

Email: _____

Supporting Social Worker: _____ Agency: _____ Phone: _____

Family Physician: _____ Paediatrician/Specialists: _____

Date Referred: _____ Referred By: _____
Agency Phone

- Legal Guardian has given informed consent for this referral: Y N
- Legal Guardian is aware speech and language services are integrated between the CDC and Northern Health: Y N
- Legal Guardian is aware CDC services are integrated with Aboriginal Supported Child Development, and the School District: Y N

Reason for Referral:

Relevant Medical History: (diagnosis, extended hospital visits, communicable diseases, medical alerts i.e. seizures, allergies, EpiPen)
Please send all relevant medical reports to Child Development Centre/Northern Health.

Services Requested (please check✓):

Physiotherapy	Occupational Therapy	Speech Therapy	Daycare	McGhee House	SCDP	Family Services
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Office use only: Consents faxed

Running Change of Information

DATE: _____

Staff Name: _____

Address: _____

Phone (home, work, emer. contact, cell, msg): _____

Parent Information: _____

Doctor (Paed.): _____

Other information: _____

DATE: _____

Staff Name: _____

Address: _____

Phone (home, work, emer. contact, cell, msg): _____

Parent Information: _____

Doctor (Paed.): _____

Other information: _____

DATE: _____

Staff Name: _____

Address: _____

Phone (home, work, emer. contact, cell, msg): _____

Parent Information: _____

Doctor (Paed.): _____

Other information: _____

DATE: _____

Staff Name: _____

Address: _____

Phone (home, work, emer. contact, cell, msg): _____

Parent Information: _____

Doctor (Paed.): _____

Other information: _____