

# Request for Services

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

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

**Child's Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Gender:** M / F / X  
First Name, Last Name Month/Day/Year

**PHN#:** \_\_\_\_\_ **Identify as Indigenous? Y/N** **English:**  Other: \_\_\_\_\_ **Interpreter Needed: Y/N**  
(Personal Health Number) (for MCFD Statistics)

**Legal Guardian:** \_\_\_\_\_ **Phone:** \_\_\_\_\_  
First Name, Last Name (Relationship) home cell work

**Address:** \_\_\_\_\_  
Address City Province Postal Code

**Email:** \_\_\_\_\_

**Legal Guardian:** \_\_\_\_\_ **Phone:** \_\_\_\_\_  
First Name, Last Name (Relationship) home cell work

**Address:** \_\_\_\_\_  
Address (if different than the above) City Province Postal Code

**Other:** \_\_\_\_\_ **Phone:** \_\_\_\_\_  
First Name, Last Name (Relationship) home cell work

**Address:** \_\_\_\_\_  
Address (if different than above) City Province Postal Code

**Family Physician:** \_\_\_\_\_ **Paediatrician/Specialists:** \_\_\_\_\_

**Childcare Program:** \_\_\_\_\_ **Days/Times Attending:** \_\_\_\_\_

**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 / History** (Please include specific concerns, and all relevant medical history including diagnosis, extended hospital visits, communicable diseases, medical alerts, allergies, preferred pronouns)

**\*\*Please send all relevant medical reports to Child Development Centre/Northern Health**

Please check all services that you are requesting:	Physiotherapy	Occupational Therapy	Speech Therapy	SCD	Family Services
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**Office use only:**  Consents faxed \_\_\_\_\_  Request for Services Spreadsheet  Tracking Spreadsheet (therapy only)  
 Phone for Therapy  SCD Letter \_\_\_\_\_