

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) 250-645-7710 Fax: (250) 645-7982

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
--	---------------	----------------------	----------------	-----	-----------------

Office use only: Consents faxed _____ Request for Services Spreadsheet Tracking Spreadsheet (therapy only)
 Phone for Therapy SCD Letter _____

Running Change of Information for Child: _____ DOB: _____

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: _____