Request for Services

The Child Development Centre of Prince George and District
Heart · Hope · A helping hand

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

northern health
the northern way of caring

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: _____