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

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**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: _____

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DATE: _____ Staff Name: _____

Address: _____

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

Parent Information: _____

Doctor (Paed.): _____

Other information: _____

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DATE: _____ Staff Name: _____

Address: _____

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

Parent Information: _____

Doctor (Paed.): _____

Other information: _____

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DATE: _____ Staff Name: _____

Address: _____

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

Parent Information: _____

Doctor (Paed.): _____

Other information: _____