



Referral Form

Date of Referral: _____

Child/Youth Name (Last): _____ (First): _____ (Preferred): _____

D.O.B. (DD-MM-YYYY): _____ Gender: _____

Primary Caregiver Name(s): _____ Relationship to child: _____

Address: _____

Primary Phone Number: _____ Alternate Phone Number: _____

Preferred Language of Service: _____ Email Address: _____

Legal Guardian(s): _____ Phone Number: _____

Clinical Diagnosis (if any): _____

Clinical Diagnosis Source: _____ Diagnosis Date: _____

Reason for Referral:

Service Requested:

Children's Community Network (CCN)

- Service Coordination
- Direct Funded Respite
- Fetal Alcohol Spectrum Disorder Program
- Intensive Treatment & Support Program (**Autism Diagnosis Required**)
- Urgent Response Services (**OAP Registration Required**) / OAP Number: _____
- Coordinated Service Planning (**complete the CSP Eligibility Criteria Checklist below**):

CSP Eligibility Criteria checklist:

Characteristics of child/youth with multiple and/complex special needs (Check all that apply)	Characteristics of family (Check all that apply)	Other risk factors to consider (Check all that apply)
<input type="checkbox"/> Child or youth with multiple and/or complex special needs <input type="checkbox"/> The child/youth is waiting for, involved with, or needing involvement with at least 2 agencies	<input type="checkbox"/> The family has a high level of stress and/or difficulty coping <input type="checkbox"/> The family's stress is due to a lack of coordination <input type="checkbox"/> Family complexity (i.e.: caregiver needs or multiple children with needs)	<input type="checkbox"/> Risk of family breakdown <input type="checkbox"/> Risk of school placement breakdown <input type="checkbox"/> Barriers to service



Intake (select the intake being requested):

Compass

- Investigation of Global Developmental Delay GDD Behavioural Support

NEO Kids - Infant and Child Development Services

- Infant Development Premature Pathways

NEO Kids - Children's Treatment Centre

- Occupational Therapy Physiotherapy Speech/Language Therapy

Wordplay/Jeux de mots (NBRHC) – Rural Only*

**For individuals residing in Sudbury, please contact Wordplay directly to self-refer*

- Preschool Speech and Language Services

Parent/Client in agreement with referral?

Consents Completed

Referring Agency: _____

Referent's Name: _____

Email Address: _____

Phone Number: _____