



Quesnel & District Child Development Centre

CLIENT REFERRAL

**** PARENT/GUARDIAN MUST AGREE TO REFERRAL BEING MADE****

Name _____ Date of Referral: _____

Date of birth _____ Male _____ Female _____ Personal Health # _____
(d) (m) (yr)

Parents\Guardians _____

Home Phone: _____

Cell Phone: _____

Email: _____

Address _____ V2J _____

Languages spoken in home _____

Family Physician _____ Clinic _____

Reason for referral/concerns _____

Medical history/diagnosis (include copies of relevant reports) _____

Services Requested:

Pregnancy Outreach Infant Development (Birth to 3) Supported Child Development (0 – 19)
 Occupational Therapy (Birth to 5) Physiotherapy (Birth to 5) Occupational Therapy (School Age)
 Speech-Language Pathology (Birth to School Age) Physiotherapy (School Age)

In Quesnel, the SLP waitlist is shared by the Q&DCDC and the Northern Health Speech and Language Clinic. Initial intake will be conducted at the Q&DCDC, however, children being referred for SLP services may be assigned to either facility based on the soonest available opening. This does not affect any other service a child may require from the Q&DCDC

Current services or programs _____

Past services or programs _____

Person making referral _____ Agency/program _____

I have informed parents/guardians that children referred for speech-language pathology services may be seen at either the Q&DCDC or at the Northern Health Speech & Language Clinic.

Signature _____