Here4Kids Referral Fax Form

 Fax to 1-844-4KIDS-FX

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| **[ ]  Attachments** |
| **Child Information (Prenatal/Children under age 6)** |
| Child’s Legal First/Last Name *(?)*      | Date of Birth/Due Date (mm/dd/yyyy)      | Age      | Gender      |
| Address      | City      | Postal Code      |
| Confirmed Diagnosis?[ ]  Yes [ ]  No [ ]  In Process | What is the Diagnosis?      | When Diagnosed? (date/child’s age)      | Who Diagnosed?      |
| What are the concerns & goals re: growth & development for this child? (include referral source & parent/legal guardian concerns & goals) *(?)*      |
| **Family/Contact Information (List contacts that have legal authority to complete referral)** |
| Parent/Legal Guardian First/Last Name      | Relationship      | Date of Birth(mm/dd/yyyy)      | Contact Number      | Alternate Number      |
| Parent/Legal Guardian First/Last Name      | Relationship      | Date of Birth(mm/dd/yyyy)      | Contact Number      | Alternate Number      |
| Other First/Last Name      | Relationship      | Date of Birth(mm/dd/yyyy)      | Contact Number      | Alternate Number      |
| Child lives with: [ ]  Both Parents(include both parent names on referral) OR [ ]  Mother [ ]  Father [ ]  Guardian [ ]  Other(Specify)       |
| Custody Arrangement (where applicable)        | Languages spoken in the home      | Interpreter Required? [ ]  Yes [ ]  No |
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| **Referral(s) Requesting (Check all that apply)**  |
| **Services for children residing in Guelph & Wellington County (Growing Great Generations System of Care)**  |
| *[ ] Canadian Mental Health Association Waterloo Wellington:**[ ]  Children’s Mental Health Program 0-6**[ ]  Infant and Child Development Program* |
| *[ ]* *County of Wellington Children’s Early Years Division (NOTE: NOT FOR USE BY Family & Children Services)* *(How long will child require child care?) [ ]  Less 6 months [ ]  More than 6 months*  |
| *[ ]  KidsAbility Centre for Child Development:**[ ]  Occupational Therapy (OT) [ ]  Physiotherapy (PT)* *[ ]  Social Work (Only available if referring to OT/PT)*  |
| *[ ]  WDG Public Health: Healthy Babies Healthy Children Program* |
| *[ ]  Wee Talk Preschool Speech & Language Service System* |
| **Services for children residing in Dufferin County** |
| *[ ]  Dufferin Child & Family Services – Infant and Child Development Program* |
| *[ ]  WDG Public Health: Healthy Babies Healthy Children Program* |
| *[ ]  Wee Talk Preschool Speech & Language Service System* |
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|  **MANDATORY CONSENT** |
|  **Parent/Legal Guardian Consent to Referral(s) provided:**  *[ ]*  Yes  | **Type of Consent:** *[ ]*  Verbal [ ]  Written  |
|  |
| **Referral Information** |
| *Original Referring Source*       | *Contact Number*       |
| *Contact Name*       | *Contact Fax*       | *Date*       |
| **\*\*\*Your printed name on this form signifies your signature and acknowledgement that you have reviewed the information contained in this form with the parent/legal guardian and the parent/legal guardian has consented to share this information for the purpose of accessing service(s) within the Dufferin and Wellington County areas.** |

**Referral Fax Form: Completion Key**

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| **Purpose:**  | * Child requires a referral listed on the Here4Kids Referral Fax Form
* Child is 0-6 years of age AND lives in Wellington County or Dufferin
* Note: some developmental services will have eligibility criteria that limit referrals to less than 6 years of age. In these cases, Here4Kids will identify alternate resources with parents, and will communicate with referring source when a referral has/has not been completed.
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| **Consent** | * Consent must be obtained for referral. Child’s parent/legal guardian will NOT be contacted to complete the referral process without consent clearly indicated. Attach written consent if obtained.
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| **Attachments** | * Check if additional reports/notes are attached to referral
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| **Child’s Legal Name** | * Indicate child’s legal first name followed by legal last name. If making a prenatal referral indicate name as “prenatal” followed by mother’s last name (i.e. Prenatal Smith)
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| **Diagnosis (Dx)** | * If the child has a medical diagnosis, include diagnosis, the date they were diagnosed and by whom
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| **Concerns & Goals** | * Describe in detail your concerns for the child and why the referral is being made (developmental concern, developmental delay, family risk)
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| **Family /Contact Information** | * Indicate parent/legal guardian/other name(s), contact information, and living arrangements. List contacts that have legal authority to complete the referral
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| **Referral(s) Request** | * Indicate the service(s) to which you are referring the child; as well as services currently involved.
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| **CMHA: Infant and Child Development Program** | * Child has developmental delay or concern, including children with diagnoses or syndromes, traumatic birth
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| **CMHA: Children’s Mental Health Program** | * Child has mental health concerns including: experienced traumatic events, affect disorder, adjustment reactions, regulatory disorders, sleeping and eating problems, attachment difficulties, social/emotional/behavioural concerns
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| **County of Wellington Children’s Early Years Division** | * A child with or without developmental delay, for whom environmental, biological, psychosocial or familial risk exists that could be supported through a child care program. The child is between the ages of 0-5 and not yet attending school.
* NOTE: NOT FOR USE BY Family and Children Services
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| **DCAFS: Infant and Child Development** | * Child has developmental delay or at risk for delay, including children with diagnoses or syndromes, early trauma, traumatic birth
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| **KidsAbility: Physiotherapy** | * Child has difficulties with movement, balance, coordination, motor planning, or activities such as sitting, crawling, walking, jumping, and using a ball, etc.
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| **KidsAbility: Occupational Therapy**  | * Child has difficulties with self-care and daily routines, response to sensory input, attention to task, feeding and hand, play or social skills
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| **KidsAbility: Social Work** | * Focus on concerns related to the personal and family impact of raising a child with communication, physical and/or developmental disabilities. Child has to be referred to OT/PT to be eligible.
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| **WDG Public Health: Healthy Babies, Healthy Children Program** | * For families parenting a child (or children) from birth up to transition to school, where risk factors exist that may challenge positive developmental outcomes.
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| **Wee Talk Preschool Speech & Language Service System** | * Child has risk factors/delays in speech and language development or presents with difficulties in speaking, understanding language, stuttering, or interacting with others
 |
| **Referral Information** | * Indicate your name, agency (if applicable) contact number, contact fax and date of completion
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**Do not return this sheet with referral – For your information only**