Here4Kids Referral Fax Form

Fax to 1-844-454-3739

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| **Attachments** | | | | | | | | | | | | | | | | | | |
| **Parent/Legal Guardian Consent to Referral(s) provided:** **Yes Type of Consent:**  **Verbal** **Written** | | | | | | | | | | | | | | | | | | |
| **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)** | | | | | | | | | | | | | | | | | | |
| Primary Contact First/Last Name | | | Relationship | | Date of Birth(mm/dd/yyyy) | | | | Contact Number | | | | | | | Alternate Number | | |
| Secondary Contact 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)  Yes  No | | Family & Children’s Services involved?  Yes  No | | | | | 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*  *Specialized Assessments*  *ASD  FASD*  *Specialized assessment has been discussed with family* | | | | | | | | | | | | | | | | | |
| *KidsAbility Centre for Child Development:*  *Occupational Therapy (OT)  Physiotherapy (PT)*  *Social Work*  *Preschool Speech & Language Services*  *Therapeutic Recreation* | | | | | | | | | | | | | | | | | |
| *Wellington Dufferin Guelph Public Health: Healthy Babies Healthy Children Program* | | | | | | | | | | | | | | | | | |
| **Services for children residing in Dufferin County** | | | | | | | | | | | | | | | | | |
| *Wellington Dufferin Guelph Public Health: Healthy Babies Healthy Children Program* | | | | | | | | | | | | | | | | | |
| *ErinOakKids Preschool Speech & Language Services* | | | | | | | | | | | | | | | | | |
| **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. |
| **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. |
| **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) |
| **Diagnosis (Dx)** | * If the child has a medical diagnosis, include diagnosis, the date they were diagnosed and by whom |
| **Concerns & Goals** | * Describe in detail your concerns for the child and why the referral is being made (developmental concern, developmental delay, family risk) |
| **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. * If Family & Children’s Services is involved, provide name and contact information |
| **Referral(s) Request** | * Indicate the service(s) to which you are referring the child; as well as services currently involved. |
| **CMHA: Infant and Child Development Program** | * Child has developmental delay or concern, including children with diagnoses or traumatic birth * This program does not provide service to children already diagnosed with ASD or are attending licensed child care. |
| **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 |
| **KidsAbility: Physiotherapy** | * Child has difficulties with movement, balance, coordination, motor planning, or activities such as sitting, crawling, walking, jumping, and using a ball, etc. |
| **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 |
| **KidsAbility: Speech & Language Services** | * Child has risk factors/delays in speech and language development or presents with difficulties in speaking, understanding language, stuttering, or interacting with others |
| **KidsAbility: Social Work** | * Focus on a new or pending diagnosis where information and support is needed, concerns related to the personal and family impact of raising a child with communication, physical and/or developmental disabilities. |
| **KidsAbility: Therapeutic Recreation** | * Child with disabilities needs support to develop skills, knowledge and behaviours for them to participate in, and enjoy recreation and leisure opportunities. |
| **Wellington Dufferin Guelph 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. |
| **Referral Information** | * Indicate your name, agency (if applicable) contact number, contact fax and date of completion |

**Do not return this sheet with referral – For your information only**