Children North

"Building Stronger Families"
PO Box 925
La Ronge, SK S0J 1L0
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Early Childhood Intervention Program, Cognitive Disability Strategy, Family Support Program
Father Engagement Program, Specialized Support Program, Mentorship and Respite Care
Speech Language Program, Developmental Outreach Clinic

REFERRAL FOR: (Please check all that apply)

Early Childhood Intervention (0-4):	_____	Pediatric Psychologist:	_____
Specialized Support Program:	_____	Pediatric OT:	_____
Family Support Program:	_____	SLP assessment:	_____
Cognitive Disability Strategy (0-100):	_____	Pediatric PT:	_____

TODAY'S DATE: _____
(Day) (Month) (Year)

Should be seen at La Ronge Development Outreach Clinic? Yes _____ No_____

CHILD'S NAME: _____
GENDER: Male _____ Female _____Other_____ S.H.S. # _____
BIRTHDATE: _____ AGE AT REFERRAL: _____
(Day) (Month) (Year)
BAND: _____ TREATY #: _____
METIS: ____ NON-STATUS____

PARENTS/FOSTER PARENTS/GUARDIAN: _____
***ADDRESS: Civic/Street Address _____
Box # _____ Town _____ Postal Code _____
TELEPHONE: Home: _____ Work: _____ Cell: _____
Email Address: _____

REFERRING AGENT: _____
Is referring agent a doctor? Yes _____ No _____ if so, Doctor's Signature: _____

Diagnosis: _____
Reason for Referral (please be specific including any therapies that they may require):
_____
_____
_____
_____
_____

PLEASE FILL OUT COMPLETELY. Do not leave blank spaces as this information is imperative to enroll child for services.