Empower Simcoe
BE • BELONG • THRIVE

Referral Form

☐ Family Support ☐ Let's Socialize File No: _____

Individual's Name: _____ ☐M ☐F ☐OTHER: _____

Address _____

D.O.B. _____ Individual's Health Card No: _____

Parent(s) / Guardian(s):

Parent 1	Parent 2
Name:	Name:
Address: ☐same as individual	Address: ☐ same as individual
Telephone:	Telephone:
Cell :	Cell:
Home:	Home:
Work:	Work:
E-mail:	E-mail:
Preferred Method of Contact: ☐phone ☐letter ☐email	Preferred Method of Contact: ☐ phone ☐letter ☐email
Are you in the military? ☐ Yes ☐No	Are you in the military? ☐Yes ☐ No
Best time to call:	Best time to call:

Languages spoken at home: _____

Diagnosis, if applicable:

Please describe your concerns at this time and give a brief history:

What type of information / assistance/service(s) would you like at this time?

Other Services involved /already requested? (*please specify*) (please include private services)

Family Doctor: _____ Dentist: _____

Paediatrician: _____ Physiotherapist: _____

Neurologist: _____ Speech/Language Pathologist: _____

Audiologist: _____ Infant & Child Development Worker: _____

Occupational Therapist _____ Resource Consultant: _____

School/nursery/school Day Program _____ Teacher / Special Education/ Resource Teacher: _____

Children's Treatment Network _____ Children's Aid Society: _____

Other medical / Professional Services (*Please specify)*

Completed by: _____

Relationship to Individual: _____

Parent/Guardian Signature: _____ Date: _____

OFFICE USE ONLY		
Service	Date of Referral:	Referral Source: