Children's Therapy and Family Resource Centre

801 McGill Road, Kamloops, BC V2C 6R1 Phone: (250) 371-4100 Fax: (250) 371-4120
www.kamloopschildrenstherapy.org

Referral Form – Birth to School Entry

Last Name	First Name	Middle Name	Also Known As
Date of Birth (MM/DD/YY)	Age at Referral	Gender ___ Male _____ Female	Physician

Parent/Caregiver Name(s)	Relationship to Child	
Address *(street address)*	City	Postal Code
Address *(mailing address if different from above)*	City	Postal Code

Home Phone Number	Work Phone Number	Cell Phone number	Email Address

Legal Guardian Names(s) (*if different from parent or caregiver)*	Relationship to child	Phone number
Legal Guardian Address *(street address)*	City	Postal Code

Name of Preschool, Daycare, School etc.	Grade
First Nations/Aboriginal Ancestry _____ Yes _____ No	Band Name

Allergies _____ Yes _____ No	Details of Allergies	Special Precautions

Personal Health Number	Primary Spoken Language	Primary Written Language	Interpreter Required _____ Yes _____ No

Who can refer? Anyone (Parents, Physicians, Daycares, School, etc.) may refer to our centre (with legal guardian's consent.)

Reason for Referral: (Please complete with the family)

- ☐ Kamloops Autism Program (KAP) (0-6years)
- ☐ Communication
  - ☐ Understanding ☐ Talking
- ☐ Feeding
- ☐ Fine Motor (small muscle and hand)
- ☐ Gross Motor (large muscle development)
- ☐ Parent & community resource information
- ☐ Perceptual/cognitive
- ☐ Self-care (eg. dressing, toileting, bathing)
- ☐ Play skills
- ☐ Sensory issues
- ☐ Special equipment/seating
- ☐ Splinting and casting
- ☐ Supported Child Development Program
- ☐ Single Visit Consultation
  - Reason: _____
- ☐ Other: _____

Legal Guardian Signature *(must be signed)*	
Date	Relationship to child

Please complete second page

DIAGNOSIS: _____

ASSOCIATED CONDITION(S):_____

RELEVANT HISTORY: *(attach additional reports as necessary)*

FAMILY'S MAIN CONCERN(S): *(must be completed for referral to be accepted)*

REFERRAL SOURCE: *(if different from parent)*

Name *(print or type)*	Signature	
Address	Postal Code	Phone Number
Relationship of Referral Source to Child		
Referral Taken by: ☐ In Person ☐ By Phone	Is Family aware of Referral? ☐ Yes ☐ No	

HOW DID YOU HEAR ABOUT OUR SERVICES? _____