

# 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 For Services – Birth to School Entry

Child's Last Name		Child's First Name		Middle Name	Also Known As
Date of Birth (MM/DD/YY)		Age	Gender	Personal Health Number	Physician
Name of Preschool/Daycare (if applicable)			Preschool/Daycare Contact Person		Contact Number
Indigenous Ancestry First Nation      Metis      Inuit      Other					
Allergies		Primary Spoken Language		Primary Written Language	Interpreter Required Yes      No
<b>Parent/Caregiver 1 (Name)</b>				Relationship to Child	
Physical/Street Address		Mailing Address (e.g. PO Box)		City	Postal Code
Primary Contact Number		Alternate Phone number		Email Address	
<b>Parent/Caregiver 2 (Name)</b>				Relationship to Child	
Physical/Street Address		Mailing Address (e.g. PO Box)		City	Postal Code
Primary Contact Number		Alternate Phone number		Email Address	
<b>Legal Guardian Name(s)</b> <i>(if different from parent or caregiver)</i>				Relationship to child	Phone number
Legal Guardian Address				City	Postal Code

### WHO IS MAKING THIS REFERRAL?

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

Name		Signature	
Address (if different from above)		Postal Code	Phone Number
Relationship of Referral Source to Child			
Name of Any Staff at CTFRC You Have Spoken with About This Referral			
Is Legal Guardian aware of Referral? Yes      No		Today's Date	

<b>Legal Guardian's Signature</b>	<b>Relationship to Child</b>
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**PLEASE TELL US WHY YOU ARE MAKING THIS REFERRAL (check as many as apply):**

Movement and Mobility concerns (gross motor)

Plagiocephaly/Torticollis

Equipment Needed for Safety (mobility, positioning, splinting/orthotics)

Communication concerns (understanding and/or talking)

Play and Social Skills concerns (playing with toys and other people)

Feeding/Eating concerns

Self-Care concerns (toileting, dressing, hygiene, sleeping)

Fine Motor concerns (using hands and fingers)

Sensory Processing concerns (extreme sensitivity or sensory seeking which is affecting participation in activities)

Self-Regulation concerns (managing emotions and behaviour)

Daycare/Preschool is requesting consultation around child's needs (Supported Child Development)

Have a diagnosis of Autism Spectrum Disorder and want to enroll in the Kamloops Autism Program (for children 0-6 years old)

Need Parent/Community Resource Information

**ANY DETAILS YOU WANT TO SHARE?**

**ANY RELEVANT HISTORY OR DIAGNOSTIC INFORMATION YOU WOULD LIKE TO SHARE?** (You can attach any reports that you feel are relevant)