Early Years Outreach Program Referral Form

PO Box 99; 4000 Stamp Avenue, Port Alberni, BC, V9Y 7M2
Tel: (250) 724-0202, Fax: (250) 720-3693

Part One: Child's Information			
Date of Referral (i.e. May 1, 2013)			
Outreach Worker		**File # (office use only)**	
Child's Name		**DOB (ie. May 10, 1973)**	
Gender	☐ Male ☐ Female		
First Nation			
School / Childcare Centre			

Address (where child resides)		**Parent / Guardian / Foster Parent information**	
Address		Name	
City		Phone	
Postal Code		Address (if not same as child)	

Part Two: Physician's Information			
Family Doctor		Pediatrician	

Part Three: Referral Information

Services Requested:
☐ Infant and Child Development ☐ Supported Child Development ☐ Maternal Child Health
☐ Vision / Hearing / Development Screening ☐ Infant Massage ☐ Rainbows (grief and loss)
☐ Other:______________________________

Reason for Referral / Developmental Concerns:

Part Four: Referral Source			
Referral Source		Phone	
Documentation / Reports Attached ☐ Yes ☐ No if yes, please list:		Has the parent been informed of referral ☐ Yes ☐ No	

For Office Use Only			
Accepted onto caseload Further referred to:	☐ Yes ☐ No	Date of 1st contact	