Sundrops Centre for Child Development

Referral for Service

Fax: 250 746 1636 Phone: 250 746 4135 ext. 253
5856 Clements St, Duncan, BC, V9L 3W3

Parent Aware of Referral **Yes** ☐ **No** ☐ Aboriginal Family **Yes** ☐ **No** ☐

The cutoff date for referral for therapy services is February 28th of the child's pre-kindergarten year

Referral Source: __________________________ Referral Date: _______________________________

Referral Source Contact Phone Number:____________________ Email:_________________________

Reason for Referral (be specific): ____

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Medical Concerns:____

Child's Name: ________________________________ D.O.B.:_________________________________

Preferred pronoun: ☐ she/her ☐ he/him ☐ them/they ☐ Other _____________

Age at Referral (0-5 for SLP, OT, PT, IDP; 0-12 for SCD): _______

Parent/Legal Guardian: ____

Parent/Legal Guardian: ____

Address: ____

Mailing Address (if different):____

Phone (primary): ______________ (secondary):________________ Email:______________________

Siblings D.O.B. Concerns

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Child Care Centre: ____

Contact Name: _______________________________ Phone: ________________________________

Birth Hospital: ____________________ Birth Weight: ___________ Gestation Age: _____________

Birth Complications: ____

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Family Doctor: __________________________ Pediatrician: _________________________________

Other Professional/Agencies Involved: ____

Social Worker: __________________________ SW Contact info: ______________________________

The private and personal information collected on this form is used to determine eligibility and appropriateness of services to be provided. Non-identifying statistical information may be collected, collated and distributed to support requests for funding, advocacy, resource allocation and measuring outcomes. Please refer to the Personal Information Protection Act