Here4Kids Referral Fax Form

Fax to 1-844-4KIDS-FX

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| **PARENT/LEGAL GUARDIAN CONSENT TO REFERRAL(S) CHECKED BELOW**  **Verbal**  **Written** |

**Attachments**

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| **Child Information (Prenatal/Children under age 6)** | | | | | | | | | | | | | | | | | |
| Child’s Legal First/Last Name *(?)* | | | | Date of Birth/Due Date (mm/dd/yyyy) | | | | | Age | | | | | Gender | | | |
| Address | | | | | | City | | | | | | | Postal Code | | | | |
| Confirmed Diagnosis?  Yes  No  In Process | What is the Diagnosis? | | | | | When Diagnosed? (date/child’s age) | | | | | | Who Diagnosed? | | | | | |
| What are the concerns & goals re: growth & development for this child? (include referral source & parent/legal guardian concerns & goals)  *(?)* | | | | | | | | | | | | | | | | | |
| **Family/Contact Information (List contacts that have legal authority to complete referral)** | | | | | | | | | | | | | | | | | |
| Parent/Legal Guardian First/Last Name | | Relationship | | | Date of Birth(mm/dd/yyyy) | | | Contact Number | | | | | | | Alternate Number | | |
| Parent/Legal Guardian First/Last Name | | Relationship | | | Date of Birth(mm/dd/yyyy) | | | Contact Number | | | | | | | Alternate Number | | |
| Other First/Last Name | | Relationship | | | Date of Birth(mm/dd/yyyy) | | | Contact Number | | | | | | | | Alternate Number | |
| Child lives with:  Both Parents(include both parent names on referral) OR  Mother  Father  Guardian  Other(Specify) | | | | | | | | | | | | | | | | | |
| Custody Arrangement (where applicable) | | | Languages spoken in the home | | | | | | | | Interpreter Required?  Yes  No | | | | | | |
| **Referral(s) Requesting (Check all that apply)** | | | | | | | | | | | | | | | | |
| **Services for children residing in Guelph & Wellington County (Growing Great Kids System of Care)** | | | | | | | | | | | | | | | | |
| *Canadian Mental Health Association Waterloo Wellington:*  *Children’s Mental Health Program 0-6*  *Infant and Child Development Program (Incl. ASD & FASD Teams)*  *Preterm Care Pathways* | | | | | | | | | | | | | | | | |
| *County of Wellington Children’s Early Years Division (NOTE: NOT FOR USE BY Family & Children Services)*  *(How long will child require child care?)  Less 6 months  More than 6 months* | | | | | | | | | | | | | | | | |
| *KidsAbility Centre for Child Development:*  *Occupational Therapy (OT)  Physiotherapy (PT)*  *Social Work (Only available if referring to OT/PT)*  *Therapeutic Recreation (Only available if referring to OT/PT)* | | | | | | | | | | | | | | | | |
| *WDG Public Health: Healthy Babies Healthy Children Program* | | | | | | | | | | | | | | | | |
| *Wee Talk Preschool Speech & Language Service System* | | | | | | | | | | | | | | | | |
| **Services for children residing in Dufferin County** | | | | | | | | | | | | | | | | |
| *Dufferin Child & Family Services – Infant and Child Development Program* | | | | | | | | | | | | | | | | |
| *WDG Public Health: Healthy Babies Healthy Children Program* | | | | | | | | | | | | | | | | |
| *Wee Talk Preschool Speech & Language Service System* | | | | | | | | | | | | | | | | |
| **Referral Information** | | | | | | | | | | | | | | | | |
| *Original Referring Source* | | | | | | | *Contact Number* | | | | | | | | | |
| *Contact Name* | | | *Contact Fax* | | | | | | | *Date* | | | | | | |

**\*\*\*Your printed name on this form signifies your signature and acknowledgement that you have reviewed the information contained in this form with the parent/legal guardian and the parent/legal guardian has consented to share this information for the purpose of accessing service(s) within the Dufferin and Wellington County areas.**

**Referral Fax Form: Completion Key**

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| **Purpose:** | * Child requires a referral listed on the Here4Kids Referral Fax Form * Child is 0-6 years of age AND lives in Wellington County or Dufferin * Note: some developmental services will have eligibility criteria that limit referrals to less than 6 years of age. In these cases, Here4Kids will identify alternate resources with parents, and will communicate with referring source when a referral has/has not been completed |
| **Consent** | * Consent must be obtained for referral. Child’s parent/legal guardian will NOT be contacted to complete the referral process without consent clearly indicated. Attach written consent if obtained. |
| **Attachments** | * Check if additional reports/notes are attached to referral |
| **Child’s Legal Name** | * Indicate child’s legal first name followed by legal last name. If making a prenatal referral indicate name as “prenatal” followed by mother’s last name (i.e. Prenatal Smith) |
| **Diagnosis (Dx)** | * If the child has a medical diagnosis, include diagnosis, the date they were diagnosed and by whom |
| **Concerns & Goals** | * Describe in detail your concerns for the child and why the referral is being made (developmental concern, developmental delay, family risk) |
| **Family /Contact Information** | * Indicate parent/legal guardian/other name(s), contact information, and living arrangements. List contacts that have legal authority to complete the referral |
| **Referral(s) Request** | * Indicate the service(s) to which you are referring the child; as well as services currently involved. |
| **CMHA: Infant and Child Development Program** | * Child has developmental delay or at risk for delay, including children with diagnoses or syndromes, early trauma, traumatic birth |
| **CMHA: Preterm Care Pathways** | * Preterm birth (<37 weeks) with or without developmental concerns/at risk |
| **CMHA: Children’s Mental Health Program** | * Child has mental health concerns including: experienced traumatic events, affect disorder, adjustment reactions, regulatory disorders, sleeping and eating problems, attachment difficulties, social/emotional/behavioural concerns |
| **County of Wellington Children’s Early Years Division** | * A child with or without developmental delay, for whom environmental, biological, psychosocial or familial risk exists that could be supported through a child care program. The child is between the ages of 0-5 and not yet attending school. * NOTE: NOT FOR USE BY Family and Children Services |
| **DCAFS: Infant and Child Development** | * Child has developmental delay or at risk for delay, including children with diagnoses or syndromes, early trauma, traumatic birth |
| **KidsAbility: Physiotherapy** | * Child has difficulties with movement, balance, coordination, motor planning, or activities such as sitting, crawling, walking, jumping, and using a ball, etc. |
| **KidsAbility: Occupational Therapy** | * Child has difficulties with self-care and daily routines, response to sensory input, attention to task, feeding and hand, play or social skills |
| **KidsAbility: Social Work** | * Focus on concerns related to the personal and family impact of raising a child with communication, physical and/or developmental disabilities. Child has to be referred to OT/PT to be eligible. |
| **KidsAbility: Therapeutic Recreation** | * Focus on helping children, youth and families to acquire the skills, knowledge and behaviours that will allow them to enjoy their leisure optimally, function independently with the least amount of assistance and participate as fully as possible in their community. Child has to be referred to OT/PT to be eligible. |
| **WDG Public Health: Healthy Babies, Healthy Children Program** | * For families parenting a child (or children) from birth up to transition to school, where risk factors exist that may challenge positive developmental outcomes. |
| **Wee Talk Preschool Speech & Language Service System** | * Child has risk factors/delays in speech and language development or presents with difficulties in speaking, understanding language, stuttering, or interacting with others |
| **Referral Information** | * Indicate your name, agency (if applicable) contact number, contact fax and date of completion |

**Do not return this sheet with referral – For your information only**