District of Parry Sound Social Services Administration Board

Inclusion Support Services

Referral Form

Name of Child: _____ **Date of Birth:** _____**(yyyy/mm/dd)**

Mailing Address: _____ **Town**_____ **Postal Code** _____

Location (if different from mailing address)
_____**Civic Number** _____

Parents/Guardian: _____ _____
Parent/Caregiver *Parent/Caregiver*

Telephone:
h)_____ **h)**_____
w) _____ **w)** _____
cell#) _____ **cell#)** _____
e-mail _____ **e-mail** _____

Preferred method of contact: ☐ **home phone** ☐ **cell phone** ☐ **e-mail** ☐ **text-messaging**

REFERRED BY: ☐ Parent/Caregiver ☐ Other Agency

Name: _____ ***Telephone:*** _____

Agency: _____

Address: _____

REASON FOR REFERRAL: ***(please provide details/examples on the line provided)***

- ☐ **Cognitive** _____
- ☐ **Language** _____
- ☐ **Gross Motor** _____
- ☐ **Fine Motor** _____
- ☐ **Social/Emotional** _____
- ☐ **Self-Help** _____
- ☐ **Other** _____

Is there a diagnosis? (If yes, please give a brief explanation) ***YES*** ☐ ***or*** ***NO*** ☐
_____

Is child attending a licensed child care program? ***YES*** ☐ ***or*** ***NO*** ☐
If YES, where and how often? _____

Is child attending an EarlyON Child and Family Centre? ***YES*** ☐ ***or*** ***NO*** ☐
If YES, where and how often? _____

Is referring agency continuing involvement with the family? ***YES*** ☐ ***or*** ***NO*** ☐

Parent/Caregiver(s) Signature: _____ **Date:** _____
(Signature implies consent to this referral)

Please fax to (705) 386-0150

Email to iss@psdssab.org

Or Mail to
Inclusion Support Services
PO Box 239
South River, ON P0A 1X0

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