

## 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*

Telephone: h) \_\_\_\_\_  
w) \_\_\_\_\_  
cell#) \_\_\_\_\_  
e-mail \_\_\_\_\_

*Parent/Caregiver*

h) \_\_\_\_\_  
w) \_\_\_\_\_  
cell#) \_\_\_\_\_  
e-mail \_\_\_\_\_

**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 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](mailto:iss@psdssab.org)

### Or Mail to

Inclusion Support Services, Suite 124  
1 Beechwood Drive  
Parry Sound, ON P2A 1J2

*revised January 2025*