



Richmond Supported Child Development Program

N202 5811 Cooney Rd

Richmond, BC V6X 3M1

Phone: 604-821-3359 Fax: 604-279-7048

REFERRAL / APPLICATION FORM

Please complete this form in full. Include all documents that will support this application for service. This may include reports from Doctors, Speech and Language Pathologists, Occupational and Physical Therapists, IDP Consultants, Health Nurses and Child Care Professionals, or other SCDP Consultants. If you are unsure about what to include, you can call 604 279-7016 to speak to the Program Coordinator.

FAMILY AND CHILD INFORMATION:

Child's First Name	Child's Last Name	Male <input type="checkbox"/> Female <input type="checkbox"/>	Date of Birth:
Home Address:		Postal Code:	Phone Number:
Parent / Guardian First Name	Parent/Guardian Last Name	Relationship:	Email address:
Home Address (if different from above):		Postal Code:	Phone Number:
Parent / Guardian First Name	Parent/Guardian Last Name	Relationship:	Email address:
Home Address (if different from above):		Postal Code:	Phone Number:
Siblings:		Sex:	Date of Birth:
		Male <input type="checkbox"/> Female <input type="checkbox"/>	
		Male <input type="checkbox"/> Female <input type="checkbox"/>	
Others Living in the Home:			
Are there any potential concerns with visiting the home <i>i.e parking, animals and firearms:</i>			
Is there a custody agreement in place? If so, please provide information.			
How would you like us to contact you? <input type="checkbox"/> by phone <input type="checkbox"/> by fax <input type="checkbox"/> by letter <input type="checkbox"/> by email			
First Language Spoken at Home:		Interpreter Needed? Yes <input type="checkbox"/> No <input type="checkbox"/>	

WHY ARE YOU REQUESTING SUPPORTED CHILD DEVELOPMENT?

Requires support with routine and transitions.	<input type="checkbox"/>	Requires support with social skills.
Requires support with personal care.	<input type="checkbox"/>	Requires support to meet physical needs.
Requires support with health and safety.	<input type="checkbox"/>	Requires supports with communication and behavior.

Does your child have identified concerns and a diagnosis:

CHILD CARE INFORMATION:

Current Child Care Setting: _____ Phone Number: _____

Address: _____ Contact Name: _____

Days of the week & hours of the day that your child attends childcare: _____

Does your child require extra support in his/her childcare setting? Yes No

If not enrolled in childcare, type of childcare program preferred:

Preschool Group Day Care Family Child Care Out of School Care Youth Program

Name of childcare program you have in mind including name and days: _____

SERVICES INFORMATION:

Please provide some information on other services, including doctors and other professionals involved with your child / family:

Program Name	Contact Person	Phone #	Email	Assessments Done (if applicable)	Initial

CONSENT:

Assessment documents, if available, are needed to assist with determining your child's eligibility for Richmond Supported Child Development Program. Please provide consent (below) to include documents with this referral form.

I give permission to release this referral form, and obtain written and verbal supporting documentation from those service providers I have initialed above to:

Richmond Supported Child Development Program Yes No **(Please Initial Box)**

Parent / Guardian Signature _____ Date _____

REFERRAL SOURCE INFORMATION:

Name of Person Making Referral and/or Assisting Family with Referral: _____

Referral Source Organization (if not the family): _____

Phone Number: _____ email _____

FOR INTERNAL USE ONLY

Date Referral Received: _____ Referral Received By: _____

Designated SCD Consultant /Intake Consultant: _____ Date SCD Support Services initiated: _____