

# REFERRAL FORM

Address:  
301 Dogwood St.  
Campbell River, BC V9W 2Y1  
Phone: 250-286-0955 Fax: 250-287-2676  
www.rivercityinclusion.ca

Date: \_\_\_\_\_

Does this child qualify for Indigenous services? ☐ Yes ☐ No

If the parent/guardian prefers to access programs and services through Laichwiltach Family Life Society (LFLS)

**instead of** Dogwood Place please use their referral form in place of this one.

\*Note LFLS does not have a Physiotherapy or a Fetal Alcohol Spectrum Disorder Key Worker Program

**Please indicate which Dogwood Place program(s) you are referring to. Please ✓**

- ☐ Speech and Language Program (birth to school entry) ☐ Infant Development Program (birth to 3 yrs.)  
☐ Occupational Therapy Program (birth to school entry) ☐ Supported Child Development Program (birth to 12 yrs.)  
☐ Physiotherapy Program (birth to school entry) ☐ Supported Child Development Program (age 13 +)  
☐ Feeding Consult (Occupational and Speech and Language Programs, birth to school entry)  
☐ Fetal Alcohol Spectrum Disorder Key Worker (birth to 19 yrs.)

Name of Child: \_\_\_\_\_ Gender: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ (day/month/year) Age at referral: \_\_\_\_\_

*If this child is in the care of MCFD, name of social worker:* \_\_\_\_\_

Name of parent/guardian \_\_\_\_\_ Email: \_\_\_\_\_

Phone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Mailing Address (if different) \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Name of parent/guardian \_\_\_\_\_ Email: \_\_\_\_\_

Phone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Mailing Address (if different) \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Physician Phone Number: \_\_\_\_\_

Referral Source (Name or Agency): \_\_\_\_\_ If agency, contact name: \_\_\_\_\_

Referral Source address: \_\_\_\_\_ Phone number: \_\_\_\_\_

**Reason for referral** (please complete this section):

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Does the parent/guardian agree with this referral and referral reason? ☐ Yes ☐ No

Is this child attending a childcare centre? ☐ Yes ☐ No ☐ Waitlisted

Name of centre \_\_\_\_\_ Days and times attending: \_\_\_\_\_