**REQUEST FOR SERVICES FOR INFANTS TO SCHOOL AGE**

 **Date of Request:**

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| **Personal Information** (child being referred) |
| **First Name:** | **Last Name:** | **Middle Name:** | **Date of Birth:** (mm/dd/yyyy) |
| **Address** (including mailing address)**:** | **Preferred Gender Identity:** | **Diagnosis:** |
| **City:** | **Postal Code:** | **Home Telephone #:** | **Email/Other Telephone #** (specify)**:** |
| **I M P O R T A N T**Two documents required as proof of your child’s residency before the referralcan be processed (2 most recent utility bills, a stub, a driver’s license, etc.) |

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| **Referring Agent** (individual making the referral) |
| **Agent’s Name:** | **Agency or Relationship:** |
| **Full Address:** | **Telephone Number:** |

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| **Reason for Referral** (what seems to be the problem/purpose of referral) |
| **Why are you referring this child to our Centre? What is the nature of the problem, specifically?** |
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| **Centre’s Programs** | **Services Being Requested** |
| Developmental Services for Children (0–18) | 🞎Infant Development (0-school entry age) 🞎Functional Developmental Assessment (0-school entry age)🞎Case Management (0-18) |
| Clinical and Support Services | 🞎Psychological Assessment 🞎Counselling🞎Behavior Consultation |
| Family Relief Program for Developmentally Challenged Children and Adults | 🞎Centre’s Respite Home |
| Family Relief Program for Physically Handicapped Children (0–18) | 🞎In-Home Respite Funding (0-18) |
| Out-of-Home Respite Initiative for Medically Fragile and Technologically Dependent Children (0–18) | 🞎Centre’s Respite Home (0-18)🞎Recreational Respite Funding (0-18)  |
| Independent Respite Services | 🞎In-Home Respite Funding |
| Autism Spectrum Disorder Respite Funding (0–18) | 🞎Autism Spectrum Disorder Funding (0-18) |



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| **I M P O R T A N T** |
| To process your referral in a timely manner, this referral form must be completed and returned within two months; otherwise, it will be assumed that our services are no longer required. Include documentation that will assist us such as past psychological assessments, developmental assessments, medical records, and all pertinent information regarding developmental needs of the child being referred. |

775 Campbell Street, Cornwall, Ontario K6H 7B7

**Tel.:** (613) 937-3072 1-800-267-1724 **Fax:** (613) 937-4550 [www.inspire-sdg.ca](http://www.inspire-sdg.ca)

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| **Next of Kin** (parent/guardian, etc.) |
| **Name:** | **Specify relation to child:** |
| **Address** (including mailing address)**:** **Same as child being referred**🞎 | 🞎Biological 🞎Step🞎Adoptive 🞎Guardian |
| **City:** | **Postal Code:** | **Home Telephone #:** | **Email/Other Telephone #** (specify)**:** |
| **Name:** | **Specify relation to child:** |
| **Address** (including mailing address)**:** **Same as child being referred**🞎 | 🞎Biological 🞎Step🞎Adoptive 🞎Guardian |
| **City:** | **Postal Code:** | **Home Telephone #:** | **Email/Other Telephone #** (specify)**:** |

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| **Foster Parents’ Information** (if applicable) |
| **Name of Foster Parents:** | **Agreement:** 🞎Temporary🞎Crown 🞎Supervision Order🞎Monitoring 🞎Special Needs | **Since when?**  |
| **Full Address: Same as child being referred**🞎 | **Home Number:** | **Email/Other Number** (specify)**:** |
| **City:** | **Postal Code:** | **Name of Contact Person at CAS:** |

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| **Custody/Agreement Status** (if applicable) |
| **Who has legal custody of the child being referred?** 🞎Mother 🞎Father 🞎Joint |
| 🞎Other (name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Agency or Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Visitation Rights: 🞎No 🞎Yes If yes, 🞎Supervised 🞎UnsupervisedWho?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_When?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Employment History of Parent(s)** |
| **Is (are) parent(s) currently employed?** 🞎No🞎YesIf yes, please indicate where?MotherFather |

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| **Parent(s) Education** |
| Mother’s Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Grade Level  Attained: Type of Classes: | Father’s Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Grade Level Attained: Type of Classes: |

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| **Sibling(s) History** (if applicable) |
| Name of Sibling(s) |  |  |  |
| Date of Birth |  |  |  |
| Problem/Achievement |  |  |  |

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| **Language** |
| What language do you prefer receiving your services in? 🞎English 🞎French |
| What language is spoken in the home? 🞎English only 🞎French only 🞎Both 🞎Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 🞎Mother Mother Tongue (English)🞎🞎Foster Mother (French)🞎🞎Stepmother (Other)🞎 | 🞎Mother Second Language (English)🞎🞎Foster Mother (French)🞎🞎Stepmother (Other)🞎 |
| 🞎Father Mother Tongue (English)🞎🞎Foster Father (French)🞎🞎Stepfather (Other)🞎 | 🞎Father Second Language (English)🞎🞎Foster Father (French)🞎🞎Stepfather (Other)🞎 |
| 🞎Child Referred Mother Tongue (English)🞎 (French)🞎 (Other)🞎 | 🞎Child Referred Second Language (English)🞎 (French)🞎 (Other)🞎 |
| **Correspondence and Documentation Preference:** 🞎English 🞎French |

**Is the child being referred currently involved with any other services and/or currently waiting to receive any other services?** (day care, school, therapies, healthy babies/healthy children’s program, etc.)

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| **PRESENTLY RECEIVING** | **WAITING LIST** |
| Organization | Name | Service | Organization | Service |
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**Has the child being referred received any types of services in the past?** 🞎Speech 🞎Physio 🞎OT 🞎Psych

**Pertinent Documentation to Obtain in Determining Eligibility for our Services:**

**Formal Assessment** (speech therapy, occupational therapy, physiotherapy, psychological) 🞎No 🞎Yes

If yes, Name of Agency:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Others** (Medical Records) 🞎No 🞎Yes

If yes, Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Were there any complications during the pregnancy or the delivery?** 🞎No 🞎Yes

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Premature 🞎No 🞎Yes

Low Birth Weight 🞎No 🞎Yes\_\_\_\_\_\_pounds\_\_\_\_\_\_ounces

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**UNDER 18 MONTHS OF AGE**

(Please indicate any concerns you may have had if child is older than

 18 months at the bottom of the page and/or answer the questions below)

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| **Language** |
| Does your child babble or make cooing sounds? | 🞎No 🞎Yes |
| What words can your child say? 🞎mama 🞎dada 🞎dodo 🞎bye 🞎car 🞎shoes 🞎juice | 🞎No 🞎Yes |
| Can your child respond to his name? | 🞎No 🞎Yes |
| Can your child follow simple instructions such as pick up your toys, go get your shoes? | 🞎No 🞎Yes |

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| **Gross Motor** |
| Can your child sit with no support? When? | 🞎No 🞎Yes |
| Can your child roll over? When? | 🞎No 🞎Yes |
| Can your child crawl? When?  | 🞎No 🞎Yes |
| Can your child stand holding onto furniture? | 🞎No 🞎Yes |
| Can your child stand alone? | 🞎No 🞎Yes |
| Can your child walk? | 🞎No 🞎Yes |

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| **Fine Motor** |
| Can your child pick up a small object? | 🞎No 🞎Yes |
| Can your child point to an object when he/she wants something? | 🞎No 🞎Yes |
| Can your child reach for an object that he/she wants? | 🞎No 🞎Yes |
| Can your child scribble? | 🞎No 🞎Yes |
| Can your child bring his/her hands together (clapping hands, banging two objects together)? | 🞎No 🞎Yes |
| Can your child fill and empty a large container? | 🞎No 🞎Yes |

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| **Personal – Social** |
| Can your child smile spontaneously? | 🞎No 🞎Yes |
| Can your child play pat-a-cake? | 🞎No 🞎Yes |
| Can your child wave bye-bye? | 🞎No 🞎Yes |
| Can your child drink from a cup? | 🞎No 🞎Yes |
| Can your child use a spoon or a fork? | 🞎No 🞎Yes |
| Can your child remove his clothing? | 🞎No 🞎Yes |

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| **Other** |
| Can your child track/follow an object or a person? | 🞎No 🞎Yes |
| Can your child imitate a simple activity (imitating you brushing your teeth)? | 🞎No 🞎Yes |

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**OVER 18 MONTHS TO SCHOOL ENTRY**

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| **Language** |
| Can your child speak clear words? | 🞎No 🞎Yes |
| Can your child combine words? (How many?) 🞎1 word 🞎2 words 🞎3 words 🞎full sentences | 🞎No 🞎Yes |
| Can other people understand what your child is saying? | 🞎No 🞎Yes |
| Can your child follow a sequence of two instructions (pick up your toy and come for supper)? | 🞎No 🞎Yes |
| Can your child sit and watch a short television program? | 🞎No 🞎Yes |
| Can your child sit through a story being read? | 🞎No 🞎Yes |
| Does your child know the main body parts? | 🞎No 🞎Yes |
| Can your child recite rhymes, songs? | 🞎No 🞎Yes |

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| **Colours/Numbers/Letters/Shapes** |
| Does your child know the basic four colours? 🞎blue 🞎red 🞎yellow 🞎green 🞎 more | 🞎No 🞎Yes |
| Can your child count to 10? What number can your child count to? | 🞎No 🞎Yes |
| Does your child know the ABCs? | 🞎No 🞎Yes |
| Does your child know the three main shapes? 🞎square 🞎triangle 🞎circle | 🞎No 🞎Yes |

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| **Gross Motor** |
| Can your child walk up and down the stairs by alternating feet? | 🞎No 🞎Yes |
| Can your child jump over a small object (a small toy, a hairbrush)? | 🞎No 🞎Yes |
| Can your child kick a ball? | 🞎No 🞎Yes |
| Can your child throw a ball? | 🞎No 🞎Yes |
| Can your child catch a ball? | 🞎No 🞎Yes |

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| **Fine Motor** |
| Can your child build a tower? 🞎2 cubes 🞎4 cubes 🞎6 cubes 🞎8 cubes | 🞎No 🞎Yes |
| Can your child copy a 🞎horizontal line 🞎vertical line 🞎circle 🞎square 🞎simple shapes? | 🞎No 🞎Yes |
| Can your child cut with a pair of scissors? | 🞎No 🞎Yes |
| Can your child complete a simple four-piece indented wooden peg puzzle? | 🞎No 🞎Yes |

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| **Personal – Social** |
| Is your child fully toilet trained during the day (urinating and bowel movements)? | 🞎No 🞎Yes |
| Is your child fully trained at night (urinating and bowel movements)? | 🞎No 🞎Yes |
| Can your child help around the house (pick up toys, cleaning)? | 🞎No 🞎Yes |
| Can your child brush his/her teeth? | 🞎No 🞎Yes |
| Can your child wash and dry his/her hands? | 🞎No 🞎Yes |
| Can your child dress himself/herself? | 🞎No 🞎Yes |
| Can your child pretend-play (play house, tea party)? | 🞎No 🞎Yes |

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| **Physical Problems** |
| Hearing Checked 🞎No 🞎Yes | Vision Checked 🞎No 🞎Yes |
| **Outcome** | **Outcome** |

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| **Medical Professionals** (family doctor, pediatrician, specialist, psychiatrist, etc.) |
| Name:Specialty:Address:Telephone Number: | Name:Specialty:Address:Telephone Number: |
| Name:Specialty:Address:Telephone Number: | Name:Specialty:Address:Telephone Number: |

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| **Medications** (if applicable) |
| Name of Medication | Dosage | Reason |
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| Who prescribes the medication? |

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| **Consent Section** |
| Do you consent to services? | 🞎No 🞎Yes |
| Are you giving us permission to inform the referring agent (when applicable) about the status of the referral? | 🞎No 🞎Yes |
| Do you consent to us contacting CHEO to inquire if your child has been referred to them for assessment? | 🞎No 🞎Yes |
| **Signature of Parent/Guardian: Date:** |

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| **Comments**(please include any behavioural concerns, observations, or any other pertinent information, etc.) |
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