

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 _____ |

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

Or Mail to

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