DEVELOPMENTAL SUPPORT SERVICES PROGRAM
REFERRAL FORM

WEECHI-IT-TE-WIN FAMILY SERVICES
601 Mowat Avenue
Fort Frances, Ontario
Tel: 807-274-0589
Fax: 807-274-5141

1. CHILD'S DETAILS:

Anishinaabe Name:	**Clan:**	
Full Name as it appears on Birth Certificate (First, Middle & Last):	**Community:**	
Date of Birth:	**Current Age:**	**Gender:** ☐ **M** ☐ **F** ☐ **O**
Place of Birth:	**Hospital of Birth:**	
Status Card Number (If none, please indicate if eligible for status):	**Health Card Number & Expiry Date:**	
Does the child speak any other language (s)? Please indicate other language (s):	**Does the child require an interpreter?** ☐ **Yes** ☐ **No**	
Does the child have an assigned Child in Care Worker? ☐ **Yes** ☐ **No**	**Please specify who the child in care worker is:**	

2. PLEASE INDICATE IF CHILD IS AT RISK FOR SUICIDE AND/OR SELF-HARM:

Suicide Risk	☐ **None** ☐ **Low** ☐ **Medium** ☐ **High**
Risk for Self-Harm	☐ **None** ☐ **Low** ☐ **Medium** ☐ **High**

3. PLEASE INDICATE IF YOUR CHILD HAS ANY ALLERGIES:

ALLERGY	SIGNS/SYMPTOMS	MEDICATION USED

4. PREVIOUS OR EXISTING SERVICES (PLEASE INDICATE WHAT SERVICES THE CHILD IS CURRENTLY RECEIVING OR HAS RECEIVED IN THE PAST AND WHAT AGENCY):

Previous

Service (s) Provided:	By Which Agency:	When:

Existing

Service (s) Provided:	By Which Agency:	When:

5. BIOLOGICAL PARENT'S DETAILS:

Mother's Details:	Father's Details:
Surname:	Surname:
First Name:	First Name:
Address:	Address:
Home Telephone Number:	Home Telephone Number:
Work Telephone Number:	Work Telephone Number:
Cell Number:	Cell Number:
Email Address:	Email Address:
Preferred Method of Contact:	Preferred Method of Contact:

☐ Single	☐ Common Law	☐ Married	☐ Shared Custody	☐ Sole Custody

6. CAREGIVER'S DETAILS:

Caregiver Details:	Caregiver Details:
Surname:	Surname:
First Name:	First Name:
Address:	Address:
Home Telephone Number:	Home Telephone Number:
Work Telephone Number:	Work Telephone Number:
Cell Number:	Cell Number:
Email Address:	Email Address:
Preferred Method of Contact:	Preferred Method of Contact:

7. REASON FOR REFERRAL (PLEASE CHECK ALL THAT APPLY):

☐ Fine Motor	☐ Gross Motor	☐ Functional Skills (toileting, feeding, sleeping)	☐ Learning
☐ Sensory	☐ General Attention/ Concentration	☐ Feet/ Lower Limbs	☐ Head Shape/ Positioning
☐ Vision/ Hearing	☐ Behavioral/ Emotional	☐ Play Skills	☐ Other:

8. PLEASE PROVIDE A DETAILED DESCRIPTION OF THE DEVELOPMENTAL CONCERNS IN THE SPACE PROVIDED:

9. PROVIDE A LIST OF DOCUMENTS TO BE INCLUDED WITH REFERRAL (IEP, PSYCHOLOGICAL ASSESSMENTS, DEVELOPMENTAL ASSESSMENTS, FASD/AUTISM ASSESSMENTS, ETC.):

10. LEGAL GUARDIAN (WHERE CHILD IS IN CARE):

_____ _____

Agency **Executive Director**

11. REFERRER INFORMATION:

_____ _____ _____

Title **Last Name** **First Name**

_____ _____

Contact Number **Contact Email**

_____ _____

Signature **Date**

Consent to Release of Information must be signed by parent or Executive Director of Agency where children are in care or the referral will be incomplete.