Cochrane Temiskaming Infant and Child Development Program
Programme de développement du nourrisson et de l'enfant de la région de Cochrane Temiskaming
www.ctrc.on.ca A Program of the Cochrane Temiskaming Resource Centre general@ctrc.on.ca

REFERRAL FORM

Services are provided to infants and children until school entry

Date of Referral: _____
Name of Child:_____ Date of Birth:_____
Gender: ☐ Female ☐ Male Chronological Age: _____
Preferred Language of Service: ☐ English ☐ French
Mother's Name: _____ Father's Name:_____
Telephone Number(s):_____ Telephone Number(s): _____
Email Address: _____ Email Address: _____
Lives with Parents: ☐Yes ☐ No
Child's Address:_____ City:_____ Postal Code: _____
Telephone Number(s):_____ PO Box: _____
Name of Legal Guardian: _____
Telephone Number(s):_____

REASON FOR REFERRAL (Please check each item that applies)

☐Developmental Delay: Please give details: _____
_____
☐ Premature: Gestational Age:_____ Birth weight: _____
☐ Periventricular Bleed ☐ Respiratory Distress ☐ Retinopathy of Prematurity
☐ Feeding Issues ☐ Motor Delay/Abnormal Muscle Tone
☐ Seizure ☐ Prenatal Exposure to Drug/Alcohol
☐ Diagnosis:_____
☐ Psychosocial Risk ☐ Language Delay ☐ Social Communication Delay
☐ Medical: _____
Additional Information:
_____
_____

Other Services Involved:_____

REFERRAL SOURCE

Name:_____ Role/Relationship:_____
Telephone Number:_____ Ext: _____
Mailing Address:_____
Parent/Legal Guardian Signature:_____

Revised May 2019