Richmond Supported Child Development Program
#280 – 7000 Minoru Blvd
Richmond , BC V6Y 3Z5
Phone: 604-279-7010 Fax: 604-279-7048

REFERRAL / APPLICATION FORM

Please complete this form in full. Include all documents that will support this application for service. This may include reports from Doctors, Speech and Language Pathologists, Occupational and Physical Therapists, IDP Consultants, Health Nurses and Child Care Professionals or other SCDP Consultants. If you are unsure about what to include, you can contact 604 279-7010 to speak to the Program Coordinator, Carrie McLellan.

FAMILY AND CHILD INFORMATION:

Child's Name:	Male ☐ Female ☐	Date of Birth:
Home Address:	Postal Code:	Phone Number:
Parent / Guardian:	Relationship:	Date of Birth:
Home Address:	Postal Code:	Phone Number
Parent / Guardian:	Relationship:	Date of Birth:
Home Address:	Postal Code:	Phone Number

Siblings:	Sex:	Date of Birth:
	Male ☐ Female ☐	
	Male ☐ Female ☐	
	Male ☐ Female ☐	
	Male ☐ Female ☐	

Others Living in the Home:	Relationship to Child

Are you a Canadian Citizen? Yes ☐ No	If NO, what is your status?

How would you like us to contact you? ☐ by phone ☐ by fax ☐ by letter

First Language Spoken at Home: ______________________________ Interpreter Needed? Yes / No

We would like to be able to have accurate information to plan future funding.
If desired, please self-identify your aboriginal status. Yes / No (circle one)

To assist us with cultural planning, you may identify the Nation you would like to be associated with. ____________________.
Is there a person that you would like us to contact from your identified Nation?

Name	Phone:

SUPPORTED CHILD DEVELOPMENT REFERRAL /APPLICATION FORM - PAGE 2

Is your child on any medication? (please list) ____________________

Why are you requesting Supported Child Development? (reason for referral; child's needs and/or diagnosis):____________________

____

____

CHILD CARE INFORMATION:

Current Child Care Setting: ____________________ Phone Number: ____________________

Address: ____________________

Contact Name: ____________________ When did your child start at this program? ____________________

Days of the week & hours of the day that your child attends childcare: ____________________

Previous Child Care Setting: ____________________

Were supports required: Yes ☐ No ☐

If yes, what type(s) of support: ☐ **Supported Child Development Consultant** ☐ **Shared extra staffing** ☐ **Individual extra staffing**

If not enrolled in childcare, type of childcare program preferred:

( ) Preschool
( ) Group Day care
( ) Family Child Care
( ) Out of School Care
( ) Youth Program

Name of childcare program you have in mind (if applicable): ____________________

How will you take your child-to-child care? ☐ by car ☐ on the bus ☐ walks ☐ other: ____________________

For out-of school care program, please complete:

Child's School:	Grade:	Phone:
Teacher's Name:	School Contact:	

OTHER SERVICES INFORMATION

Please provide some information on other services, including doctors and other professionals, involved with your child / family:

Name of Service Provider	Agency Name	Phone #	Address	Assessments Done (if applicable)	Consent (Initial)

SUPPORTED CHILD DEVELOPMENT REFERRAL / APPLICATION FORM - PAGE 3

Assessment documents, if available, are needed to assist with determining your child's eligibility for Supported Child Development. Please provide consent (below) to include documents with this referral form.

CONSENT:

I give permission to release this referral form, and supporting documentation from those service providers I have initialed above, too:

Richmond Supported Child Development Program Yes ☐ No ☐ (please initial)

Child Care Program(s) including ____ Yes ☐ No ☐ (please initial)
(name(s) of child care programs)

_ ________________________
Parent / Guardian Signature Date

REFERRAL SOURCE INFORMATION:
Name of Person Making Referral and/or Assisting Family with Referral: ____

Referral Source Organization (if not the family): ____

Phone Number: ________________________________

I give permission to obtain written and verbal information regarding my child from this referral source (where this is not the family):

Richmond Supported Child Development Program Yes ☐ No ☐ (please initial)

______________________________________ ______________________________
Parent / Guardian Signature Date

______________________________________ ______________________________
Signature of Witness to Referral Form Date

FOR INTERNAL USE ONLY
Date Referral Received: ______________________ Referral Received By: ____

Designated SCD Consultant /Intake Consultant: ____

Date SCD Support Services Initiated: ____