RSCL 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 call 604 279-7016 to speak to the Program Coordinator.

FAMILY AND CHILD INFORMATION:

Child's First Name	Child's Last Name	Male ☐ Female ☐	Date of Birth:
Home Address:		Postal Code:	Phone Number:
Parent / Guardian First Name	Parent/Guardian Last Name	Relationship:	Email address:
Home Address (if different from above):		Postal Code:	Phone Number:
Parent / Guardian First Name	Parent/Guardian Last Name	Relationship:	Email address:
Home Address (if different from above):		Postal Code:	Phone Number:
Siblings:		Sex:	Date of Birth:
		Male ☐ Female ☐	
		Male ☐ Female ☐	
Others Living in the Home:			
Are there any potential concerns with visiting the home *i.e parking, animals and firearms:*			
Is there a custody agreement in place? If so, please provide information.			
How would you like us to contact you? ☐ by phone ☐ by fax ☐ by letter ☐ by email			
First Language Spoken at Home:		Interpreter Needed? Yes ☐ No ☐	

WHY ARE YOU REQUESTING SUPPORTED CHILD DEVELOPMENT?

Requires support with routine and transitions.		Requires support with social skills.	
Requires support with personal care.		Requires support to meet physical needs.	
Requires support with health and safety.		Requires supports with communication and behavior.	

Does your child have identified concerns and a diagnosis?:

CHILD CARE INFORMATION:

Current Child Care Setting: _____ Phone Number: _____

Address:_____Contact Name:_____

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

Does your child require extra support in his/her childcare setting? Yes □ No □

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 including name and days:_____

SERVICES INFORMATION:

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

Program Name	Contact Person	Phone #	Email	Assessments Done (if applicable)	**Initial**

CONSENT:

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

I give permission to release this referral form, and obtain written and verbal supporting documentation from those Service providers I have initialed above to:

Richmond Supported Child Development Program ***(Please Initial)*** Yes _____ No _____

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: _____ email_____

FOR INTERNAL USE ONLY

Date Referral Received: _____ Referral Received By: _____

Designated SCD Consultant /Intake Consultant: _____ Date SCD Support Services initiated: _____