Richmond Supported Child Development Program
N202 5811 Cooney Rd
Richmond, BC V6X 3M1
Phone: 604-821-3359 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 Yes ☐ No ☐ ***(Please Initial Box)***

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: ______________