George Jeffrey Children's Centre
ENRICHING CHILDREN'S LIVES

SERVICE REQUEST

CLIENT INFORMATION:

Full Name: _____ Gender: Male Female

Date of Birth: (yyyy)_____ / (mm) ___ / (dd) ___ Ontario Health Card #: _____

Address: _____ Postal Code: _____

Guardian Name: _____ Primary Phone Number: _____

Alternative Number:_____ Child Care/School: _____

Email Address: _____ (optional – email unencrypted)

SERVICE REQUEST (each service request must have a reason for referral):

☐ Occupational Therapy: _____

☐ Physiotherapy: _____

☐ Speech Language Pathology: _____

☐ Augmentative & Alternative Communication: _____

☐ Seating and Mobility: _____

☐ Feeding and Swallowing Clinic: _____

☐ Infant Growth and Development Clinic (at risk infants birth to 3 – due to neonatal or birth history):

_____

OTHER INFORMATION (known diagnosis, urgent concerns, medical needs, agencies involved):

_____

_____

_____

_____

REFERRANT INFORMATION (Guardian must consent to referral):

Name/ Agency: _____

Address: _____Telephone: _____

Signature: _____ Date: _____

* (Please attach any relevant reports or additional information)