George Jeffrey
Children's Centre
ENRICHING CHILDREN'S LIVES

SERVICE REQUEST

CLIENT INFORMATION:

Last Name: ______________________ First Name: ______________________ Sex: _______

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

Address: ____ Postal Code: ______________

Phone#:_____________ Primary Language: ______________

Child Care/School: ___________________________ Physician (if known)_________________________

PARENT/GUARDIAN INFORMATION:

Name: ________________________________ Relationship to client: _____________________ Custody Y☐ N☐

Address: ☐ same as client ____ Postal Code: ______________

Phone#: (home) _______________ (cell) ______________ (work) ______________

Email Address: ________________________________ (optional – email unencrypted)

Name: ________________________________ Relationship to client: _____________________ Custody Y☐ N☐

Address: ☐ same as client ____ Postal Code: ______________

Phone#: (home) _______________ (cell) ______________ (work) ______________

Email Address: ________________________________ (optional – email unencrypted)

SERVICE REQUEST (each service request must identify specific concerns for referral):

☐ Occupational Therapy: ____

☐ Physiotherapy: ____

☐ Speech Language Pathology: ____

☐ Augmentative & Alternative Communication: _______________________________________

☐ Seating and Mobility: ____

☐ Feeding and Swallowing Clinic: ____

OTHER INFORMATION (known diagnosis, risk factors at birth, urgent concerns, medical needs, agencies involved):

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REFERRANT INFORMATION (Guardian must consent to referral):

Name/Agency (print): ____

Address: ____ Phone#: ___________Fax#: ______________

Signature: ____ Date: __________________________

* (Please attach any relevant reports or additional information)