Services:
Infant Development
Family Services
Family Support
Occupational Therapy
Physiotherapy
Speech-Language Therapy
Supported Child Care
Preschool

1135 Nelson Street
Nanaimo B.C. V9S 2K4
Telephone: 250-753-0251
Fax: 250-753-5614
Email: info@nanaimocdc.com
www.nanaimocdc.com

REFERRAL FORM

Referral Date: ______________________

Has parent/guardian been informed and agree to referral? ☐ Yes ☐ No
If no, this referral cannot be processed.

Child's Last Name: ______________ **First Name:** ______________

Birth Date (M/D/Y): ______________ **Age:** ________ **Male** ☐ **Female** ☐

Care Card #: ______________ **Pediatrician(s):** ______________

Family Doctor: ______________ **Address/Clinic:** ______________

Address/Clinic: ______________

Child's Address (if different than below) ______________

Parent/Guardian: ______________ **Telephone:** ______________
Address: ______________ **Alternate:** ______________
City: ______________ **Postal Code:** ______________

Parent/Guardian: ______________ **Telephone:** ______________
Address: ______________ **Alternate:** ______________
City: ______________ **Postal Code:** ______________

Reason for Referral:
____
____
____
____
____
____

Information taken by: ______________

Referral Source: ______________ **/Parent** ☐
Agency: ______________
Address: ______________
______________ **Postal Code:** ______________
Phone Number: ______________

For Office Use Only
Zone ☐ CEN ☐ NOR ☐SOU
☐ Initial
☐ External
☐ Internal