FIVE COUNTIES CHILDREN'S CENTRE REFERRAL FORM

(for Parent/Legal Care Custodian or Professional Use)

Please complete and send to: 872 Dutton Road, Peterborough, ON K9H 7G1 or FAX 705-748-3526 / Phone: 1-888-779-9916 x100		
Child's Name:	**DOB:** dd/mmm/yyyy	**Gender:**
Address:		
City:	**Postal Code:**	**County:** Choose:
Parent Name:	**Phone:**	☐ **Cell** ☐ **Home**
Address and Email Address (if different from above):		
Parent Name:	**Phone:**	☐ **Cell** ☐ **Home**
Address and Email Address (if different from above):		
Legal Care Custodian (if not Parent) Name:	**Phone:**	☐ **Cell** ☐ **Home**
Child Care or School Attending:		
Diagnosis (if known):		
Physician/Other Agencies Involved:		

Requested Assessment		**Reason for Referral:**
Occupational Therapy	☐	
Physiotherapy	☐	
Speech Therapy	☐	
Seating and Mobility	☐	
Feeding	☐	
Therapeutic Recreation	☐	
Social Work	☐	
Augmentative Communication Service	☐	

Parent/Legal Care Custodian Signature:	**Date:**
Parent/Legal Care Custodian Signature:	**Date:**

OR, Referral Completed by:	**Name:**
	Phone:
Date:	**Name of Parent/Guardian Consenting to this referral:**

Physician/Nurse Practitioner Referral Required for the following services:

Child's HC#:	**Reason for Referral:**
☐ **ASD Diagnostic Assessment**	
Orthopaedic Clinic	**Temporarily unavailable. Please refer to Physiotherapy.**
☐ **Tone Management Clinic**	Dr. Mark Mason - Physiatry - for consult and consideration of Botox Intervention
Referring Physician/NP Name:	
Referring Physician Billing #:	**Phone:** **Fax:**
Physician/NP Address:	
Signature:	**Date:**