



inclusion
powell river

inclusion powell river Child and Family Services
6831 Artaban Street, Powell River, B.C. V8A 4B9
Phone: 604-483-4042
Fax: 604-483-4443

Referral to Child and Family Services Programs

Child's Last Name First Name Date of Birth (yyyy/mm/dd)

Parent/Guardian Name Relationship

Parent/Guardian Name Relationship

Address Postal Code Phone Number

Services requested:

- Infant Development Program (0-3 years)
- Supported Child Development Program (3+ years)
- Occupational Therapy (0-6 years)
- Occupational Therapy (School Age)
- Physiotherapy (0-6 years)
- Complex Developmental Behavioural Condition Key Worker Services

Reason for Referral:



Current Programs and Services (if applicable):

I have informed the family of my referral to the above services and they are expecting to be contacted by each service requested.

- Yes
- No – please explain by phone or letter.
- Not applicable (self-referral)

The parents/guardians have given consent for the status of the referral to be shared with the referral source

- Yes
- No
- Not applicable (self-referral)

Referral Source Contact Info:

Name (please print)	Agency (if applicable)	Date of Referral
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Telephone	Email Address
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Please fax this form to 604-483-4443