



**North Shore
Neighbourhood
House**

supported child development program

309 west 1st street
north vancouver, bc v7m 1b5
t: 604.998.0131
f: 604.998.0134
www.nsscdp.com

REFERRAL / APPLICATION FORM

Please complete this form in full. Include all documents that will support this application for service. This may include reports from Doctors, Speech and Language Pathologists, Occupational and Physical Therapists, IDP consultants, Health Nurses and Child Care Professionals or other SCDP Consultants. If you are unsure about what to include, you can contact the SCD program for further information by calling 604 998-0131 to ask the Coordinator or a Consultant.

FAMILY AND CHILD INFORMATION:

| | | |
|------------------------------|---------------------------------------------------------------|--------------------|
| Child's Last Name: | Child's First Name: | Middle Name: |
| Medical Health Number | Female <input type="checkbox"/> Male <input type="checkbox"/> | Date of Birth: |
| Home Address: | Postal Code: | Home Phone Number: |
| City: | Province: | |

| | | |
|--------------------|---------------|------------------|
| Parent / Guardian: | Relationship: | Work/Cell Number |
| Home Address: | Postal Code: | Phone Number |
| City: | Province | |
| Parent / Guardian: | Relationship: | Work/Cell Number |
| Home Address: | Postal Code: | Phone Number |
| City: | Province: | |

| | | |
|-----------|---------------------------------------------------------------|----------------|
| Siblings: | Sex: | Date of Birth: |
| | Male <input type="checkbox"/> Female <input type="checkbox"/> | |
| | Male <input type="checkbox"/> Female <input type="checkbox"/> | |
| | Male <input type="checkbox"/> Female <input type="checkbox"/> | |

| | |
|-------------------------------------------------------------------------------------------|-----------------------------|
| Are you a Canadian Citizen? Yes <input type="checkbox"/> No <input type="checkbox"/> | If NO, what is your status? |
|-------------------------------------------------------------------------------------------|-----------------------------|

How would you like us to contact you? by phone by fax by letter by email _____

First Language Spoken at Home: _____ Interpreter Needed? Yes / No

MCFD would like to be able to have accurate information to plan future funding.
If desired, please self-identify your aboriginal status. Yes / No (circle one)

SUPPORTED CHILD DEVELOPMENT REFERRAL/APPLICATION FORM

Is your child on any medication? (please list) _____

Why are you requesting Supported Child Development? (reason for referral; child's needs and/or diagnosis): _____

Please give a brief description of your child's abilities, needs, personality, behaviour and/or any other information you want to tell us about your child:

CHILD CARE INFORMATION:

Current Child Care Setting: _____ Phone Number: _____

Address: _____

Contact Name: _____ When did your child start at this program? _____

Days of the week & hours of the day that your child attends child care: _____

Previous Child Care Setting: _____

Were supports required: Yes No

If yes, what type(s) of support: **SCDP Consultant** **Shared extra staffing** **Individual extra staffing**

If not enrolled in child care, type of child care program preferred: Preschool _____ Group Day care _____
Family Child Care _____ Out of School Care _____

Name of child care program you have in mind (if applicable): _____

How will you take your child to child care? by car on the bus walk other: _____

For out-of school care program, please complete:

| | | |
|-----------------|-----------------|--------|
| Child's School: | Grade: | Phone: |
| Teacher's Name: | School Contact: | |

OTHER SERVICES INFORMATION

Please provide some information on other services, including doctors and other professionals, involved with your child / family:

| Name of Service Provider | Agency Name | Phone # | Assessments Done (if applicable) | Consent (Initial) |
|--------------------------|-------------|---------|----------------------------------|-------------------|
| | | | | |
| | | | | |
| | | | | |

SUPPORTED CHILD DEVELOPMENT REFERRAL/APPLICATION FORM

ASSESSMENT DOCUMENTS, IF AVAILABLE, ARE NEEDED TO ASSIST WITH DETERMINING YOUR CHILD'S ELIGIBILITY FOR SUPPORTED CHILD DEVELOPMENT.

PLEASE PROVIDE CONSENT (BELOW) TO INCLUDE DOCUMENTS WITH THIS REFERRAL FORM.

Consent:

I give permission to release this referral form, and supporting documentation from those service providers I have initialed above, too:

North Shore Supported Child Development Program Yes No (please initial)

Child Care Program(s) including _____ Yes No (please initial)
(name(s) of child care programs)

Parent / Guardian Signature _____ Date _____

REFERRAL SOURCE INFORMATION:

Name of Person Making Referral and/or Assisting Family with Referral: _____

Referral Source Organization (if not the family): _____

Phone Number: _____

I give permission to obtain written and verbal information regarding my child from this referral source (where this is not the family):

North Shore Supported Child Development Program Yes No (please initial)

Parent / Guardian Signature Date

Signature of Witness to Referral Form Date

FOR INTERNAL USE ONLY

Date Referral Received: _____ Referral Received By: _____

Designated SCD Consultant /Intake Consultant: _____

Date SCD Support Services Initiated: _____

Notes: _____

