☐ 400 McKeown Ave North Bay, ON P1B 0B2 1-866-626-9100 (705) 476-5437 Fax: (705) 474-0127	☐ 100 Frank Miller Drive Unit 2, Box 7 Huntsville, ON P1H 1H7 1-866-232-5559 (705) 789-9985 Fax: (705) 789-1115	☐ 70 Joseph Street Unit 304 Parry Sound Mall Parry Sound, ON P2A 2G5 (705) 746-6287 Fax: (705) 746-5324

REFERRAL FORM - CHILDREN'S TREATMENT CENTRE SERVICES

NOTE: This information will be shared with One Kids Place staff as required

Date of Referral:
Day Month Year

Parent's Signature: ________________________________.

☐ Verbal consent obtained from guardian

Person Completing This Referral: ________________________________.

Relationship to Child: ________________________________.

CLIENT INFORMATION

Client's Name (Last, First, Initial):		Date of Birth (Day, Month, Year):	Sex: M F
Address:			
Postal Code:		Telephone (Home):	
Health Number and Version *(Optional)* :		Family Doctor:	Phone:
Pediatrician:	Phone:	School / Daycare:	Grade:
Language(s) Spoken by the Child:		Service Language:	

FAMILY IDENTIFICATION

Mother's Name:	Address (☐ same as above):		Telephone (Home): (Work): Cell:
Father's Name:	Address (☐ same as above):		Telephone (Home): (Work): Cell:
Custody Status: ☐ Both	☐ Mother	☐ Father	☐ Other/ Special arrangements
Legal Guardian:	Relationship to Child:	Phone:	Address:

☐ Waitlist ☐ Therapist assigned ________________ ☐ Services currently open ____________________
Notes: ____
____

One Kids Place Referral Form (Continued):

SERVICES BEING REQUESTED:	☐ **OT** (Occupational Therapy)	☐ **PT** (Physiotherapy)	☐ **SLP** (Speech-Language Pathology)	☐ **SW** (Social Work)	☐ **TR** (Therapeutic Recreation)	☐ **ABA** (Autism Services)	**CLINIC:** ☐ Developmental ☐ Healthy Bodies ☐ Orthotics ☐ AAC (Augmentative and Alternative Communication) ☐ Feeding/ Swallowing ☐ Seating

HEALTH / MEDICAL CONCERNS

Reason for Referral (Please attach assessment report(s) if applicable):	
Please list any specific questions/issues to be addressed: 1. 2. 3. 4. 5.	
Allergies:	
Primary diagnosis	When Diagnosed *(if applicable)*
Other Diagnosis	When Diagnosed *(if applicable)*

STRENGTHS	**DISLIKES / DIFFICULTIES**

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