County: _____

DEVELOPMENTAL RESOURCES FOR INFANTS
BIRTH TO TWO YEARS
REFERRAL FORM
FAX TO: 519-685-8705

SURNAME: _____ FIRST NAME: _____ ALIAS: _____

DATE OF BIRTH: _____ _____ _____ SEX: MALE: ☐ FEMALE: ☐ AGE AT REFERRAL: _____
YEAR MONTH DAY

HEALTH CARD _____ VC: _____

HOSPITAL WHERE BORN: _____ GESTATIONAL AGE AT BIRTH: _____ BIRTH WEIGHT: _____

LEGAL GUARDIAN: _____

ADDRESS: _____ CITY/POSTAL CODE: _____

PHONE NUMBER (Home): _____ WORK: _____ CELL: _____

CHILD LIVES WITH: _____

ADDRESS: _____ CITY/POSTAL CODE: _____

PHONE NUMBER (Home): _____ WORK: _____ CELL: _____

FAMILY PHYSICIAN: _____ PEDIATRICIAN: _____

REFERRAL SOURCE (contact person): _____

ADDRESS: _____ CITY/POSTAL CODE: _____

PHONE NUMBER: _____ REFERRAL DATE: _____

REASON FOR REFERRAL:

OTHER SERVICES INVOLVED:

I agree with the referral to Developmental Resources for Infants. I understand that information about my child and family will be shared with the agencies as described in the DRI brochure* I may choose a level of service mutually agreeable to myself and the agencies involved and I will be involved in planning for my child. This consent is valid for the length of time my child is receiving coordination of resources from Developmental Resources for Infants OR while receiving services from one of the participating agencies. I understand that I may revoke this consent in writing at any time.

☐ Verbal consent _____ _____
Received by Date

_____ _____
Signature of Parent/ Legal Guardian Date

* **CHILD AND PARENT RESOURCE INSTITUTE HOME VISITING PROGRAM FOR INFANTS**

* **CHILDREN'S HOSPITAL, LHSC DEVELOPMENTAL FOLLOW-UP CLINIC**

* **THAMES VALLEY CHILDREN'S CENTRE**

REVISED: Aug 2019