Children's Therapy Collective
Referral Form

Child & Parent Information:

Please fill out information that is known. Areas can be left blank if the information is not known.

Child's Name:	Child's DOB:
Name of Parent(s)/Caregiver(s):	
Parent/Caregiver Email Address:	
Parent/Caregiver Phone #:	

Please fill out section below <u>if</u> child is involved with Child and Family Services:

Legal Guardian (if different from above):
Legal Guardian Email Address:
Legal Guardian Phone Number:
Agency Name:

Clinical Services:

Please select the service(s) that you are referring the child to:

- ☐ Physiotherapy
- ☐ Occupational Therapy
- ☐ Speech-Language Pathology
- ☐ Counselling

Reason for Referral:

Please describe the reason(s) for referral.

Referral Source:

Name of Person Completing Referral:
Role:
Email Address:
Phone Number:

Please send completed referrals to info@childrenstherapycollective.com, or by fax to 431-305-5704.

The information in this form is protected by the privacy provisions of the Freedom of Information and Protection of Privacy Act (FIPPA) and the Personal Health Information Act (PHIA). This information may also be shared under the Provisions of the Protection of Children (information sharing) Act (PCISA).