



REACH CHILD AND YOUTH DEVELOPMENT SOCIETY  
#3 – 3800 72<sup>ND</sup> STREET  
DELTA, BC, V4K 3N2

**Office Use Only:**  
Date received: \_\_\_\_\_  
Sharevision: \_\_\_\_\_

## OCCUPATIONAL THERAPY REFERRAL FORM

Date of referral: \_\_\_\_\_

Urgent; should be seen a.s.a.p.

Reason for urgency: \_\_\_\_\_

Child's Name: _____	Date of birth: _____	<input type="checkbox"/> M / <input type="checkbox"/> F
Address: _____		
City: _____	Postal Code: _____	
Mother's Name: _____	Phone (H): _____ (C): _____	
E-mail: _____		
Father's Name: _____	Phone (H): _____ (C): _____	
E-mail: _____		
Child's present status: <input type="checkbox"/> Natural <input type="checkbox"/> Adopted <input type="checkbox"/> Foster <input type="checkbox"/> Other; describe _____		
<input type="checkbox"/> First Nations		
Social Worker (if applicable): _____		Phone: _____
Address: _____		Postal Code: _____

**Birth History:** Birth Weight: \_\_\_\_\_ Gestational Age: \_\_\_\_\_

### Referral Data:

Diagnosis: \_\_\_\_\_

Source of referral:  IDP  SCD  PHN  PARENT  OTHER \_\_\_\_\_

Name of referral source: \_\_\_\_\_

Address: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone: \_\_\_\_\_

Reason for referral:

- |   |   |
|---|---|
| <input type="checkbox"/> Fine motor delays  | <input type="checkbox"/> Feeding                        |
| <input type="checkbox"/> Self-care concerns | <input type="checkbox"/> Equipment needs or positioning |
| <input type="checkbox"/> Sensory            | <input type="checkbox"/> Other: _____                   |

Parent/caregivers' concerns:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Other programs involved:**

Service	Previous	Current	Waitlist	Contact	Phone
B.C. Children's Hospital and/or Sunny Hill					
Fraser Health Assessment Network					
Infant Development Program					
Supported Child Development Program					
Speech-Language Therapy					
Physiotherapy					
Other (i.e. preschools, daycare, therapist, etc):					

**Please attach any relevant documentation such as assessments or reports.**

**Medical Information:**

Family Doctor: \_\_\_\_\_

Pediatrician: \_\_\_\_\_

Other Physicians Involved: \_\_\_\_\_

Hearing tested  Results: \_\_\_\_\_

Vision tested  Results: \_\_\_\_\_

Additional Medical Concerns: \_\_\_\_\_

I \_\_\_\_\_ (parent/guardian) give my permission for \_\_\_\_\_ to be seen by *Reach Child and Youth Development Society* Occupational Therapy Department, for the purpose of developmental assessment and intervention as required. If foster parent, please have the child's Social Worker sign.

\_\_\_\_\_/\_\_\_\_\_  
Signature Date

I \_\_\_\_\_ (parent/guardian) give my permission for the referral information of \_\_\_\_\_ to be shared between *Reach Child and Youth Development Society* and *the Centre for Child Development*, for the purpose of waitlist management.

\_\_\_\_\_/\_\_\_\_\_  
Signature Date

