reach
CHILD AND YOUTH DEVELOPMENT SOCIETY
"BELIEVING IN POTENTIAL"

5050 47th Avenue
Delta, BC V4K 0C8
Phone: 604.946.6622
Fax: 604.946.6223
www.reachchild.org
info@reachchild.org

Early Intervention Therapies
Referral Form

Office Use Only:
Date received: _____
Sharevision: _____

Please complete all sections of this form.

Child and Family Information:		
Date of Request *(dd/mm/yyyy)*:	Gender: ☐ Male ☐ Female ☐ Other:	
Child's First Name:	Child's Middle Name:	Child's Last Name:
Preferred Name:	Date of Birth *(dd/mm/yyyy)*:	Age:
Address:	City:	Postal Code:
☐ Parent or ☐ Legal Guardian Name: Primary phone: Address (if different from child): Email:	☐ Parent or ☐ Legal Guardian Name: Primary phone: Address (if different from child): Email:	
Language/s child speaks:	Home Language:	
Interpreter needed: ☐ Yes ☐ No	Does family identify as First Nations, Metis, or Inuit? ☐ Yes ☐ No	

Referral Source:
☐ Parent / caregiver ☐ Social Worker ☐ Physician / healthcare provide ☐ Childcare ☐ IDP / SCD / ASCD ☐ Early Intervention Therapies staff ☐ Other
☐ Parent / Guardian is aware of this request (if the referrer is not parent / guardian)
Referrer name and role: / Referrer contact info:

Reasons for Referral: select all that apply	
☐ Behaviour Support	• Does the child have challenges with behaviours (e.g., dysregulated behaviours, self-injury, aggression, dangerous or unsafe behaviours, difficulty with transitions) • Do you have concerns about the child's social skills or interactions with others? • Does the child have multiple needs and require a coordinated plan with consistent strategies across home and community settings?
☐ Occupational Therapy	• Does the child have difficulty with using their hands to play with toys, use crayons, or cut with scissors? • Do you have concerns about the child's self-help skills (e.g., dressing, toileting, hygiene)? • Does the child have sensory processing concerns (sounds, movement, touch etc.)? • Do you have concerns about the child's diet or feeding skills (e.g., chewing, using utensils, mealtime participation, or oral-motor concerns)
☐ Physiotherapy	• Do you have concerns about the child's ability to sit, crawl, stand, walk, run, jump, or climb? • Do you have concerns about the child's strength, balance and coordination, muscle tone, posture, or motor coordination?
☐ Speech Therapy	• Do you have concerns about the child's language understanding, using words and sentences, articulating words, fluency? • Do you have concerns about the child's interaction and communication with others?

If you have selected only 'Speech Therapy', please check all below boxes that apply.	
☐ Difficult to understand	☐ Voice problems (scratchy, raspy, or nasal sounding)
☐ Stutters (repeats sounds and words) for example, ba-ba-ba-balloons: the-the-the car	☐ Child does not understand language or cannot follow directions
☐ Speaks few words for age	☐ Behaviour (aggression, tantrums, impulsiveness)
☐ Difficulty forming sentences	☐ Other, please describe:

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Concerns for autism or developmental delay, please describe: ☐ Child has been referred for autism assessment: ☐ Sunny Hill ☐ Private:
Please describe your main concern/s:
'Reach' and 'The Centre for Child Development' both provide Occupational therapy, Physiotherapy, and Speech therapy services to families in Delta. There is one coordinated waitlist for services. By submitting this form, you agree that Reach shares the information provided here with The Centre for Child Development. Please indicate where you would like to receive Occupational therapy, Physiotherapy, and Speech therapy services: ☐ Only 'Reach' ☐ Either 'Reach' or 'The Centre for Child Development' (whichever is available to provide service first) *****Please note, if you have selected 'speech therapy' only as a reason for referral, and there are no other concerns related to developmental delay, autism, or behaviours, services might be provided by Fraser Health.

Other services involved
☐ Pediatrician ☐ Social worker ☐ Mental health/counselling ☐ OT ☐ PT ☐ SLP ☐ IDP ☐ SCD ☐ ASCD ☐ Other, please describe: *Please list all services that the child is receiving/has received.
Does the child have a diagnosis: ☐ No ☐ Yes (please write)
Please list child's allergies:
Are any of the allergies anaphylactic: ☐ No ☐ Yes (please describe):
Are child's immunizations up to date: ☐ Yes ☐ No (please describe):
Referral submission information:

• For online submission, please either scan the QR code provided here or go to the following link:
https://reachdevelopment.org/child-development-programs/therapies/
 	
• You can fax your completed referral to one of these numbers:
  ○ Therapies Program: 236.480.7532 (preferred)
  ○ REACH Main: 604.946.6223
 	
• You can mail it to or drop it in person at:
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