Child Development Centre
of Prince George and District
1687 Strathcona Avenue, Prince George, BC V2L 4E7
Phone: (250) 563-7168 Fax: (250) 563-8039

Request for Services

Speech & Language Clinic
1444 Edmonton Street, Prince George, BC V2M 6W5
Phone: (250) 565-7370 Fax: (250) 565-7386

Child's Name:_____ D.O.B: _____ Gender: M/F
First Name, Last Name Month/Day/Year

PHN#: _____ _____ _____ English: ☐ Other: _____ Interpreter Needed: Y/N Aboriginal: Y /N (for MCFD Statistics)

Legal Guardian:_____(_____) Phone: _____ _____ _____
First Name, Last Name (Relationship) home cell work

Address: _____ _____ _____ _____
Address City Province Postal Code

Legal Guardian 2: _____(M, F, SW, FP) Phone: _____ _____ _____
First Name, Last Name (Relationship) home cell work

Address: _____ _____ _____ _____
Address City Province Postal Code

Email: _____

Other: _____(M, F, SW, FP) Phone: _____ _____ _____
First Name, Last Name (Relationship) home cell work

Address: _____ _____ _____ _____
Address City Province Postal Code

Email: _____

Supporting Social Worker: _____ Agency: _____ Phone: _____

Family Physician: _____ Paediatrician/Specialists: _____

Date Referred: _____ Referred By: _____ _____ _____
Agency Phone

→Legal Guardian has given informed consent for this referral: Y☐ N ☐
→Legal Guardian is aware speech and language services are integrated between the CDC and Northern Health: Y☐ N ☐
→Legal Guardian is aware CDC services are integrated with Aboriginal Supported Child Development, and the School District: Y☐ N ☐

Reason for Referral:

Relevant Medical History: *(diagnosis, extended hospital visits, communicable diseases, medical alerts i.e. seizures, allergies, EpiPen)*

Please send all relevant medical reports to Child Development Centre/Northern Health.

Services Requested (*please check*✓**):**

Physiotherapy	Occupational Therapy	Speech Therapy	McGhee House	SCDP	Family Services

Office use only: ☐ Consents faxed

Running Change of Information

DATE: _____ Staff Name: _____

Address: _____

Phone (home, work, emer. contact, cell, msg): _____

Parent Information: _____

Doctor (Paed.): _____

Other information: _____

DATE: _____ Staff Name: _____

Address: _____

Phone (home, work, emer. contact, cell, msg): _____

Parent Information: _____

Doctor (Paed.): _____

Other information: _____

DATE: _____ Staff Name: _____

Address: _____

Phone (home, work, emer. contact, cell, msg): _____

Parent Information: _____

Doctor (Paed.): _____

Other information: _____

DATE: _____ Staff Name: _____

Address: _____

Phone (home, work, emer. contact, cell, msg): _____

Parent Information: _____

Doctor (Paed.): _____