Services:
Infant Development
Family Development
Occupational Therapy
Physiotherapy
Speech-Language Therapy
Supported Child Development

NANAIMO CHILD DEVELOPMENT CENTRE
Opening Doors®

1135 Nelson Street
Nanaimo B.C. V9S 2K4
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Fax: 250-753-5614
Email: info@nanaimocdc.com
www.nanaimocdc.com

REFERRAL FORM

Referral Date: _____

Has parent/guardian been informed and agree to referral? ☐ Yes ☐ No (**If no, this referral cannot be processed)**

Does parent/guardian require an interpreter? ☐ Yes ☐ Parent/guardian consents to being contacted by interpreter

Child's Last Name: _____ **First Name:** _____

Birth Date (M/D/Y)**:** _____ **Age**: _____ **Male** ☐ **Female** ☐

Care Card #: _____ **Pediatrician(s):** _____

Family Doctor: _____ **Address/Clinic**: _____

Address/Clinic: _____

Child's Address (if different than below) _____

Parent/Guardian: _____ **Telephone:** _____
Address: _____ **Alternate:** _____
City: _____ **Postal Code:** _____

Parent/Guardian: _____ **Telephone:** _____
Address: _____ **Alternate:** _____
City: _____ **Postal Code:** _____

Reason for Referral:

_____

_____

_____

_____

_____

_____

Information taken by: _____

Referral Source: _____ **/Parent** ☐

Agency: _____

Address: _____

_____ **Postal Code:** _____

Phone Number: _____

For Office Use Only
☐ **NOR** ☐ **NOR CEN** ☐ **SOU CEN** ☐ **SOU**
☐ **Initial IC/DC**
☐ **External**
Assigned to _____

Operated by: Nanaimo Child Development Centre Society
"Over 50 years of community service"