Referral Information Form
– Children's Inclusion Support Services

600 - 700 Industrial Avenue, Ottawa, Ontario K1G 0Y9
613-736-1913 ext. 231 613-736-8378 (fax)
intake-ciss@afchildrensservices.ca

Child's Name: _____ _____
(First) (Last)

Date of Birth: _____ Sex: _____
Month / Day / Year

Home Address: _____ Apt./Unit # _____

City: _____ Postal Code: _____

Telephone Number(s): Home _____

Parent Name: _____ Cell _____ Work _____

Parent Name: _____ Cell _____ Work _____

Guardian Name: _____ Cell _____ Work _____

Parent/Guardian E-mail Address: _____

Language(s) spoken in the home: ❒ English ❒ French ❒ Other _____

Indicate preferred language for correspondence: ❒ English ❒ French

Current and/or previous programs, and/or therapy (place/worker):

_____

State child care program already attending: _____

Permission to call the child care program ❒ Yes ❒ No

Medical Concerns: _____

Type of child care program option required:

❒ Child Care Centre ❒ Nursery School ❒ Home Child Care Agency

Date of Service required: _____

Referred by: Contact Person: Telephone:

_____ _____ _____
Social Worker/or other

If applicable and with given permission, please send a copy of the child's diagnosis assessment report with this referral.

_____ _____
Signature of Parent/Guardian Date

August 2019

Print

Please complete, print the form, sign it and send it to us by e-mail, mail or fax.