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: _____ Gender: _____
(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

Medical Concerns: _____

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

_____

State the program the child is currently attending: _____

If the child is not attending a child care program, select option(s) you are considering:

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

Date of Service required: _____

Referred by:

_____ _____ _____
Contact Person Social Worker/ or Other Telephone

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

_____ _____
Parent/Guardian Signature Date (Month/Day/Year)