Terrace Child Development Centre

MAIN OFFICE: 2510 South Eby Street, Terrace, B.C. V8G 2X3
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www.terracechilddevelopmentcentre.ca

PEDIATRIC REFERRAL

Child's Last Name	Child's First Name	D.O.B. (Month/Day/Year)	☐Male ☐Female

Mother's Name		Father's Name	
Address		Address	
City	Postal Code	City	Postal Code
Home Phone	Work Phone	Home Phone	Work Phone
Cell Phone	e-mail	Cell Phone	e-mail

Do parents consider child to have First Nations Heritage? (used for MCFD stats)			☐Yes ☐No
Primary Language of Family:	☐English ☐Other	Interpreter Required:	☐Yes ☐No
Reason for Referral:			
Other Significant Medical Details / Past History:			

Hearing Tested?	☐Yes ☐No	Date:	Vision Tested?	☐Yes ☐No	Date:
If hearing has not been tested, has a referral been sent?				☐Yes ☐No	Date:

Family History:			
Current Preschool or Day Care:			Days Attending:
Family Physician:		Medical Specialists Involved:	
Other Agencies Involved:		Involved with Park Centre?	☐Yes ☐No
Referral Agent (please print):		Signature	
Are parents aware of this referral	☐Yes ☐No	Date:	Telephone:

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Referral Meeting Date:	Parents Informed? ☐Yes ☐No	Date:
To give Background Information, parent requests contact by: ☐Home Visit ☐Centre Visit ☐Telephone		
Parent prefers to be contacted: ☐Mornings ☐Afternoons	Days:	
First Contact Date:	Assessment Date:	

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