Terrace Child Development Centre 

REFERRAL FORM

Referral Date: _____

Has parent/guardian been informed and agree to referral?

☐ Yes

☐ No, if no this referral cannot be processed

Child/Youth's Last Name _____ First Name _____

Birth Date (M/D/Y) _____ Gender _____

Family Doctor _____ Pediatrician _____

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

Describe your concerns/How can we support your child/youth?

_____

_____

_____

_____

Form Completed by: _____		
Referral Source: _____		
Agency:	Phone Number:	Email:

Family Connection Centre and Head Office: 2510 Eby Street Terrace, B.C. V8G 2X3 Phone: 250-635-9388 Toll Free:1-877-770-8795 **Fax: 250-638-0213** Email: cdct@telus.net

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