Empower Simcoe
BE • BELONG • THRIVE

Referral Form

☐ Family Support ☐ Let's Socialize ☐ Option C File No: _____

Individual's Name: _____ ☐M ☐F ☐OTHER: _____

Address _____

D.O.B. (DD-MM-YYYY): _____ CTN No: _____

Parent(s) / Guardian(s):

Parent/Guardian 1	Parent/Guardian 2
Name:	Name:
Address: ☐same as individual	Address: ☐ same as individual
Telephone:	Telephone:
Cell :	Cell:
Home:	Home:
Work:	Work:
E-mail:	E-mail:
Preferred Method of Contact: ☐phone ☐email	Preferred Method of Contact: ☐ phone ☐email
Are you an active military member? Yes ☐ No ☐	Are you an active military member? Yes ☐ No ☐
Best time to call:	Best time to call:

Languages spoken at home: _____ Interpreter Required? Yes ☐ No ☐

Diagnosis:

Intellectual Developmental Disorder Yes ☐ No ☐ Psychological Assessment Provided Yes ☐ No ☐

Other:

Please describe your concerns at this time and give a brief history:

What **type** of information / assistance/service(s) would you like at this time?

Other Services involved /already requested? (*please specify*) (please include private services)

	Active	Waitlist
Family Doctor: _____	☐	☐
Paediatrician: _____	☐	☐
Neurologist: _____	☐	☐
Dentist: _____	☐	☐
Physiotherapist: _____	☐	☐
Speech/Language Pathologist: _____	☐	☐
School: _____		
Teacher: _____		
Children's Treatment Network: _____	☐	☐
Occupational Therapist: _____	☐	☐
OAP No: _____	☐	☐
Simcoe Muskoka Family Connexions: _____		

Other medical / Professional Services (*Please specify)*

Referring Person's Name: _____

Referring Person's Contact: _____

Relationship to Individual: _____

Parent/Guardian Signature: _____ Date: _____

- ☐ Consent to contact referral source
- ☐ Consent to create CTN Shared Client Record
- ☐ Consent to view CTN Shared Client Record
- ☐ Family Consents to Referral