# BIRTH TO "SCHOOL START"
# SPEECH-LANGUAGE PATHOLOGY
# REFERRAL FORM
# FOR QUALITY CHILD CARE NIAGARA

**Tel: 905-688-1890 ext. 110 | *Fax: (905) 688-9181***
**567 Glenridge Avenue, St. Catharines, ON L2T 4C2**

**Date referral form completed** (DD/MM/YYYY): ___/___/_____

**Referral portal available on Niagara Children's Centre website if preferred**

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**Section 1: Child's Information**

Child's First and Last Name: _________________________________ Date of Birth (DD/MM/YYYY): ___/___/_____

Postal Code and City of Child's Home Address __________________________

Child's first language __________________________

**Additional Concerns**
**Please briefly list any other concerns with the child's development in the space below.**

***Important**: By providing this information, you are not referring to other Centre services. This information, however, will help guide the Intake Coordinator's conversation with the parent/legal guardian to ensure all appropriate Centre and community referrals are made in line with the Centre's established eligibility criteria and community service pathways.*

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**Section 2: Parent/Legal Guardian Contact Information**

Parent/Legal Guardian First and Last Name (please print): __________________________

Relationship to child (parent, legal guardian): __________________________

Primary Phone #: _____-______-________ Email: __________________________________

Cellphone Number (for text reminders): _____-______-________ ☐same as primary phone

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**Section 3: Requester Information** Enter the information about the person sending this referral (NOT the parent/legal guardian).

Agency/Organization Name where the child was seen: __________________________

Who completed this referral (please print first name and last name): _________________________________

Role: __________________________ Phone Number: __________________________

Agency/Organization Type:

☐ EarlyON Centre ☐ Child Care Centre

☐ Licensed Home Child Care (Wee Watch) ☐ Licensed Home Child Care (Niagara Region)

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**Section 4: Other Information**

**Speech and Language Referral Checklist was completed:**

☐ As per QCCN schedule (6-8 weeks after starting Child Care or annual anniversary of last Checklist completion)

☐ Upon Parent/Guardian concern/ request, outside of QCCN schedule

☐ Upon Educator concern, outside of QCCN schedule

**Please ensure:**

☐ The child resides in Niagara (regardless of where the child attends Child Care)

☐ Speech and Language Referral Checklist is attached

☐ The child is not currently involved with/waiting for speech-language pathology at the Niagara Children's Centre

**Please indicate if the child is involved with a:**

- Resource Consultant: ☐ Yes ☐ No ☐ Referral in progress
  - If yes or in progress, provide name and agency: ___________________________
- QCCN Behaviour Consultant: ☐ Yes ☐ No ☐ Referral in progress
  - If yes or in progress, name: ___________________________

**If the child/family's first language is not the primary language of the childcare:**
Service is available in English and French.

- Will the parent/legal guardian need an interpreter for another language on the intake call? ☐ Yes ☐ No
  If yes, indicate language spoken including dialect, for an interpreter ___________________________
- Will you (the requester) provide assistance during the intake call?
  ☐ Yes, a parent/guardian will require support from me to answer questions on the intake call
  ☐ No, a parent/guardian can independently answer questions on the intake call
- Could you (the requester) confirm that the parent/guardian has concerns in child's primary language?
  ☐ Yes ☐ No

**Section 5: Release of Information/Consent**

☐ I confirm I am a parent with decision-making authority OR a legal guardian of this child

☐ I consent to the referral for Speech and Language Assessment at the Niagara Children's Centre

☐ I consent to add this personal health information to the Niagara Children's Centre electronic health record. I understand that Niagara Children's Centre is funded by the Ministry of Children, Community, and Social Services and consent to this information being added to the Ministry of Children, Community, and Social Services' database.

☐ I consent to the sharing of information regarding my child between Niagara Children's Centre and all agencies/organizations listed under "Requester Information"

**If applicable:**

☐ I consent to send this personal health information to Niagara Children's Centre via the Secure Online Referral Portal.

☐ I consent to the sharing of information regarding my child between Niagara Children's Centre and the **Resource Consultant Agency and/or the QCCN Behaviour Consultant** connected to my child's child care provider indicated above. This consent is valid if my child is actively in service with these consultants or service is initiated within 1 year of the date below.

**Parent/Legal Guardian Name** (Please PRINT full name): ___________________________

**Parent/Legal Guardian Signature:** ___________________________

**Date of Signature** (DD/MM/YYYY): ___/___/_____