Form G1-1

Referral Form

☐ Parent/Guardian has consented to this referral

Please call 519-354-0520 ext. 0 for more information about our services.

Date: _____ Preferred Language: ☐English ☐French ☐Other: _____

Client Name: _____D.O.B.: _____Gender: ☐Male☐Female ☐Other_____

Address:_____

Name of Legal Guardian(s):_____

Contact Telephone #'s: _____

Requested Service(s) for Ages 0 to 6 years:

☐Physiotherapy ☐Occupational Therapy ☐ Speech/Language Pathology

☐Audiology: ☐Child ☐Adult

***For all School Based Rehabilitation Services referrals and Central Auditory Processing Assessment (CAP) (Grade 1 and up), please contact your school principal or Learning Resource Teacher.

Please describe your concerns: _____

_____

_____

_____

_____

Who is completing this form: _____

Address: _____

Telephone #: _____

The Children's Treatment Centre of Chatham-Kent will contact the family by telephone after we receive this referral. After completing, please email to info.forwarding@childrenstreatment-ck.com, fax (519-354-7355), or mail to the address below.

Celebrating Abilities, Developing Potential

355 Lark Street Chatham, Ontario N7L 5B2 Tel: 519-354-0520 Fax: 519-354-7355
www.childrenstreatment-ck.com

Revised: September 2022