Children's TREATMENT CENTRE OF CHATHAM-KENT

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 #: ______________________ Email Address:

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