Early Intervention 0-5 Years Occupational Therapy Services Referral Form

Sechelt Health Unit
Occupational Therapy Services 0-5
PO Box 1040, 5571 Inlet Ave
Sechelt, BC,V0N 3A0
Phone: 604-885-5164
Fax :604-885-9725

Please fill in this form as well as you can. If there is a question that does not apply to you or your child, please skip it.

Person filling out this form: _____ Relationship to child: _____

Is the parent/guardian aware of this referral? ☐ Yes ☐ No Phone Number for Referral Source: _____

Date form was completed: _____ [For Office Use Only] PARIS ID: _____

CHILD'S INFORMATION			
Child's FIRST Name	Child's LAST Name		Date of Birth *(day/month/year)*
Personal Health Number	Gender	Do you want an interpreter? ☐ No ☐ Yes Which Language?	
Address *(including postal code)*		Best Phone Number	

☐Parent/☐Legal Guardian/☐Foster Parent (first name, last name)			☐Parent/☐Legal Guardian/☐Foster Parent (first name, last name)		
Address *(including postal code)* ☐ Same as child's address			Address *(including postal code)* ☐ Same as child's address		
How does Parent prefer to be contacted? Home Ph:	C ell Ph:	Work Ph:	How does Parent prefer to be contacted? Home Ph:	Cell Ph:	Work Ph:
Email:	Text:	Relationship to Child:	Email:	Text:	Relationship to Child:

Other People Living In the Home	Relationship to Child	Age (If Under 18)

YOUR CONCERNS:
What worries you most about this child?
What are your concerns about this child's participation in activities of daily living? eg. feeding, dressing toileting, play
Is there any other information you feel is important for us to know?

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