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North Shore Neighbourhood House

Supported Child Development Program
225 East 2nd Street
North Vancouver BC V7L 1C4
T: 604 998-0131 E: roberta@nsscdp.com
W www.nsscdp.com

REFERRAL / APPLICATION FORM

Please complete this form in full. Include all documents that will support this application for service. This may include reports from Doctors, Speech and Language Pathologists, Occupational and Physical Therapists, IDP consultants, Health Nurses and Child Care Professionals or other SCDP Consultants. If you are unsure about what to include, you can contact the SCD program for further information by calling 604 998-0131 to ask the Manager or a Consultant.

FAMILY AND CHILD INFORMATION:

Child's Last Name:	Child's First Name:	Middle Name:
Medical Health Number	☐ Male ☐ Female	Date of Birth:
Home Address:	Postal Code:	Home Phone Number:
City:	Province:	

Parent / Guardian:	Relationship:	Work/Cell Number:
Home Address:	Postal Code:	Phone Number:
City:	Province	
Parent / Guardian:	Relationship:	Work/Cell Number:
Home Address:	Postal Code:	Phone Number
City:	Province:	

Siblings:	Sex:	Date of Birth:
	☐ Male ☐ Female	
	☐ Male ☐ Female	
	☐ Male ☐ Female	

Are you a Canadian Citizen? ☐ Yes ☐ No	If NO, what is your status?

How would you like us to contact you? by phone by fax by letter by email _____

First Language Spoken at Home: _____ Interpreter Needed? ☐ Yes ☐ No

MCFD would like to be able to have accurate information to plan future funding.

If desired, please self-identify your aboriginal status ☐ Yes ☐ No

SUPPORTED CHILD DEVELOPMENT REFERRAL/APPLICATION FORM

Is your child on any medication? (please list) _____

Why are you requesting Supported Child Development? (reason for referral; child's needs and/or diagnosis): _____

_____

Please give a brief description of your child's abilities, needs, personality, behaviour and/or any other information you want to tell us about your child:

CHILD CARE INFORMATION:

Current Child Care Setting: _____ Phone Number: _____

Address: _____

Contact Name: _____ When did your child start at this program? _____

Days of the week & hours of the day that your child attends child care: _____

Previous Child Care Setting: _____

Were supports required: ☐ Yes ☐ No

If yes, what type(s) of support: **SCDP Consultant** **Shared extra staffing** **Individual extra staffing**

If not enrolled in child care, type of child care program preferred: ☐ Preschool ☐ Family Child Care ☐ Group Day Care ☐ Out of School Care

Name of child care program you have in mind (if applicable): _____

How will you take your child to child care? ☐ by car ☐ on the bus ☐ walk ☐ other: _____

For out-of school care program, please complete:

Child's School:	Grade:	Phone:
Teacher's Name:	School Contact:	

OTHER SERVICES INFORMATION

Please provide some information on other services, including doctors and other professionals, involved with your child / family:

Name of Service Provider	Agency Name	Phone #	Assessments Done (if applicable)	Consent (Initial)

SUPPORTED CHILD DEVELOPMENT REFERRAL/APPLICATION FORM

ASSESSMENT DOCUMENTS, IF AVAILABLE, ARE NEEDED TO ASSIST WITH DETERMINING YOUR CHILD'S ELIGIBILITY FOR SUPPORTED CHILD DEVELOPMENT.

PLEASE PROVIDE CONSENT (BELOW) TO INCLUDE DOCUMENTS WITH THIS REFERRAL FORM.

Consent:

I give permission to release this referral form, and supporting documentation from those service providers I have initialed above, too:

North Shore Supported Child Development Program ☐ Yes ☐ No

Child Care Program(s) including _____ ☐ Yes ☐ No
(name(s) of child care programs)

Parent / Guardian Signature_____ Date_____

REFERRAL SOURCE INFORMATION:
Name of Person Making Referral and/or Assisting Family with Referral: _____

Referral Source Organization (if not the family): _____

Phone Number: _____

I give permission to obtain written and verbal information regarding my child from this referral source (where this is not the family):

North Shore Supported Child Development Program ☐ Yes ☐ No

_____ _____
Parent / Guardian Signature Date

_____ _____
Signature of Witness to Referral Form Date

FOR INTERNAL USE ONLY
Date Referral Received: _____ Referral Received By: _____
Designated SCD Consultant /Intake Consultant: _____
Date SCD Support Services Initiated: _____
Notes: