Child Development Centre "Together, we can reach the stars"

REFERRAL FORM

PO Box 2703
Whitehorse, Yukon
Y1A 2C6
Phone: 867-456-8182
Fax: 867-393-6374
Toll Free: 1-866-835-8386

Please Print Clearly

Date of referral _____/_____/_____
Month/Day/Year

Child's Name: _____ **DOB**___/___/___ ☐ Male ☐ Female
First Name, Middle Name, Last Name Month/Day/Year

Reason for Referral: _____

_____

_____

Mother: _____ Phone: _____ _____ Can leave message ___Y __N
Circle one: Work Home Cell Work Home Cell

Address _____Postal Code_____ Email _____
This information is for a foster parent: ___ Y ___ N

Father: _____ Phone: _____ _____ Can leave message __Y __N
Circle one: Work Home Cell Work Home Cell

Address _____Postal Code _____ Email _____
This information is for a foster parent: ___ Y ___ N

Legal Guardian: _____ Phone: _____ _____ _____
(If different than parents) Home Work Cell

Address _____Postal Code_____ Email _____

Childcare program: ☐ No ☐ Yes Name of program: _____

Primary Language: _____ Name of Doctor: _____

Child Seen at: ☐ Whitehorse Health Center ☐ Kwanlin Dun Health Center ☐ Community Health Center

The parent/guardian have been informed of this referral: ☐ Yes ☐ No

Referral Source: _____ Relationship to Child: _____

Signature of Referral Source _____

Office Use Only

File #:_____ Date Entered: _____
Referral assigned to:_____
Comments: _____
If parents are separated ☐ Joint custody ☐Sole custody _____
Waitlist policy explained Y / N