CHILD & YOUTH DIAGNOSTIC & SUPPORT TEAM - REFERRAL FORM

% Child Development Centre
P.O. Box 2703 Whitehorse, Yukon Y1A 2C6
Phone: 867-456-8182 Ext 193 - Fax: 867-393-6374

Parent/Legal Guardians must be in agreement with this referral and sign the bottom of this referral form

Please Print Clearly

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

Referral for assessment in the area of:

☐ Autism Spectrum Disorder ☐ Fetal Alcohol Spectrum Disorder ☐ Complex Behavior Concerns

Concerns _____

_____

Child/Youth lives with:

Caregiver: _____ Relationship_____Phone: _____ _____
Circle one: Work Home Cell Work Home Cell

Address _____Postal Code_____ Email _____

Caregiver: _____Relationship_____Phone: _____ _____
Circle one: Work Home Cell Work Home Cell

Address _____Postal Code _____ Email _____

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

Address _____Postal Code_____ Email _____

Primary Language: _____Childcare program:_____

School _____ Grade_____ Healthcare #_____

Name of Social Worker _____ Contact at _____

_____ _____
Signature of Parent/Legal Guardian Signature of Person making the referral

_____ _____
Print name Print name

_____ _____
Date Relationship to the child/youth

_____
Date