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**Counselling Services of Belleville & District**

12 Moira Street East, Belleville, Ontario K8P 2R9

Phone (613) 966-7413 Fax (613) 966-2357

Email: [csbd@csbd.on.ca](mailto:csbd@csbd.on.ca) Website: [www.csbd.on.ca](http://www.csbd.on.ca)

**REFERRAL FORM**

**FAMILY RESOURCE & SUPPORT**

**Family Resource & Support is for families of children birth to 17 years of age who have a diagnosed Developmental Disability and who live at home.**

# Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Child’s Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B.: \_\_\_ / \_\_\_\_ / \_\_\_\_\_ Age: \_\_\_\_

dd / mo / yr

**Parent(s)/Guardian(s)**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: (Home) \_\_\_\_\_\_\_\_\_\_\_\_\_ (Work) \_\_\_\_\_\_\_\_\_\_\_\_\_ (Cell) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Postal Code: \_\_\_\_\_\_\_\_\_\_

**Referral Source**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe the child’s Developmental Disability, i.e.: IQ of 70 or less; functioning at

or below the 2nd percentile. Provide specific diagnosis information.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Date of Last Assessment**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_By Whom: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Reason for referral**: (Please check only those that apply and provide specific details)

Resource Information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Case Planning: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Service Co-ordination: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Funding Application: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Education Support: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Physician**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Health #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Amount of Funding Received**:

ACSD $\_\_\_\_\_\_\_\_\_\_\_\_\_ SSAH $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**School**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Other Agencies or Supports Involved** (Presently or in past two years):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Other Information**:

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Signature of Parent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please attach appropriate Consent to Share Information forms**