Kenora Association for Community Living
A Meaningful and Satisfying Life

CHILDREN'S SERVICES REFERRAL FORM

First Nations Intake

☐ Infant Development Program ☐ Child and Youth Program

Date: ______________________________

Child/Youth's Name: ____

D.O.B.: ______________________________ Age: __________ ☐ Male ☐ Female

Parents/Guardians: ____

Client's relationship to primary caregiver with whom the client currently resides:

☐ Both Bio Parents ☐ Single Parent ☐ Adoptive Family ☐ Other

Legal Guardianship: ☐ Both Parents ☐ Mother ☐ Father ☐ Joint Custody ☐Other

Address: ____

Telephone Contact: (Home) ______________________ (Cell) ___________________________

Siblings/Others Living In the home: Name: __________________________ Age: ____________________
Name: __________________________ Age: ____________________

Language(s) Spoken in the Home: ____

Referral Source: ____

Daytime Contact Information: (Phone) ______________________________

Reason for Referral: ____

____

Other Agencies/School Involved: ____

Family Physician: ________________ Family Awareness of Referral (Written/ Verbal Consent)____