Referral to: **Region of Waterloo, Infant and Child Development Program**
Phone: 519-575-4400 x5002 Fax: 519-883-4288

Region of Waterloo
PUBLIC HEALTH AND EMERGENCY SERVICES

Date: _____ **Completed by:** _____

☐ I am the child's parent
☐ I am a professional assisting the referral with parental/guardian consent (verbal or written)
(Agency Name:)

Child's Name: _____ ☐Male ☐Female ☐Twin ☐Triplet

Date of Birth: _____ **Age:** _____

Expected Date of Delivery: _____(m/d/y)

Gestation: _____ wk Birth Weight: _____gm Birth Order: _____

☐ Child lives with parent(s)
☐ Child lives in foster home

First Language Spoken at Home: ☐ English ☐ French ☐ Other: _____
☐ **Interpreter is Required**

Parent Name #1: _____ ☐Male ☐Female

Address: _____**City:** _____**Postal Code:** _____

Phone: _____ **Email:** _____

Parent Name #2: _____ ☐Male ☐Female

Address: _____**City:** _____**Postal Code:** _____

Phone: _____ **Email:** _____

Guardian Name: _____ ☐Male ☐Female

Address: _____**City:** _____**Postal Code:** _____

Phone: _____ **Email:** _____

Foster Parent Name: _____ ☐Male ☐Female

Address: _____**City:** _____**Postal Code:** _____

Phone: _____ **Email:** _____

Reason for Referral:

- ☐ Developmental **delay**
- ☐ Developmental **concern**
- ☐ Syndrome: _____

Describe:

_____

_____

_____

_____

_____

_____

_____

_____

Services Involved:

Family Doctor: _____ Pediatrician: _____

☐ Home and Community Care ☐ KidsAbility ☐ Healthy Babies Healthy Children

☐ Family and Children's Services

☐ Neonatal Followup Clinic ☐ Growth and Development Clinic