



DONATE

CAPITAL CAMPAIGN

MY ACCOUNT

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LANSDOWNE CHILDREN'S CENTRE / START SERVICE / REFERRAL FORM

Referral Form

Personal Data

CHILD'S FIRST NAME**CHILD'S LAST NAME****CHILD'S DATE OF BIRTH****GENDER**

Do not know

Female

Gender Non-conforming

Intersex

Male

Other

Prefer Not to Answer

MOTHER'S NAME**PHONE NUMBER**

1-123-456-7890

SECONDARY PHONE NUMBER

1-123-456-7890

EMAIL ADDRESS

example@email.com

POSTAL CODE**FATHER'S NAME****PHONE NUMBER**

1-123-456-7890

SECONDARY PHONE NUMBER

1-123-456-7890

EMAIL ADDRESS

example@email.com

GUARDIAN'S NAME (If not parent)**RELATIONSHIP****PHONE NUMBER**

1-123-456-7890

SECONDARY PHONE NUMBER

1-123-456-7890

EMAIL ADDRESS

example@email.com

Diagnosis/Reason for Referral

Please provide details of diagnosis and/or reason for referral.

Referred Services

CHECK ALL THAT APPLY:

- Physiotherapy
- Occupational Therapy
- Speech Therapy
- Social Work (*Referral can only be made with referral for another service*)
- Autism Services (*Purchase ABA*)
- Autism Services (*Ministry Funded*)
- Child Development Program
- Early Integration Program
- Special Services at Home
- Respite Care
- Every Kid Counts
- Autism Spectrum Disorder Respite

OAP REGISTRATION #**SCHOOL****CHILDCARE****AGENCY AND POSITION****EMAIL (REQUIRED)****PHONE NUMBER (REQUIRED)****DATE OF REFERRAL (REQUIRED)**

After submitting this form, you should receive confirmation of this referral within 5 business days. If not, please call Central Intake at **519-753-3153 ext. 206** to ensure receipt of the referral.



I'm not a robot

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