



DONATE

CAPITAL CAMPAIGN

MY ACCOUNT

[About Us](#) [Start Service](#) [Our Services](#) [Fee for Service](#) [Our Team](#) [Careers](#) [Volunteers/Students](#) [Family Resources](#) [Events & News](#) [Contact](#)

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****ADDRESS****CITY/TOWN****COUNTY****POSTAL CODE**

### Contact Information

**MOTHER'S NAME****PHONE NUMBER****SECONDARY PHONE NUMBER****EMAIL ADDRESS****FATHER'S NAME****PHONE NUMBER****SECONDARY PHONE NUMBER****EMAIL ADDRESS****GUARDIAN'S NAME (If not parent)****RELATIONSHIP****PHONE NUMBER****SECONDARY PHONE NUMBER****EMAIL ADDRESS**

### 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**

### Referral Completed By

**NAME (REQUIRED)****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**Submit**