Coordinated Referral Form for Healthcare Providers
(Prenatal to Start of School)

Referral Source Name **Phone Number** **Fax Number**	**All referral forms to be faxed to:** **905-825-8821** They will be received by staff at Halton Region.

Parent/Guardian Information	**Child Information**
☐ **Parent/Guardian has consented to this referral.** Name of Parent/Guardian: Relationship to Child: Address: City: Phone**: (**H) Phone: (O) ☐ **Parent/Guardian has consented to communicate via email:** **Email Address:** **Interpreter Required:** ☐ YES ☐ NO **Language:**	Name of Child: Address: ☐ Same as parent/guardian If different, please list: **Date of Birth of Child or Estimated Date of Delivery: (DD/MM/YY):**

Referral Information (e.g., presenting concerns, relevant history, other services involved)**:**

Referral to the following Halton Region programs requested

- ☐ Infant/child development services
- ☐ Childcare Subsidy (Social/Medical referral)
- ☐ Healthy Babies, Healthy Children (HBHC) program

For other programs and services for children please visit Infant and Child Development Information for Healthcare Providers.

Consent:

The Regional Municipality of Halton is part of a network of Agencies providing services to children/families in the Halton Region in the early years. The Intake Worker will make referrals on your behalf and forward it to the identified agency program.

☐ I give my written permission for this intake to be completed and forwarded the referred to program.

Signature of referral source:	**Date of Referral:** (DD-MM-YYYY)