# PROMISE YEARS

Date:

To:

From:

Re: **Request for Referral to Child Development Clinic**

Child: ________________________________ Parent/Guardian(s): ____________________________

DOB: _________________________________ Address: ___________________________________

Phone: _______________________________

The above named child has been seen by:

*Check the appropriate boxes:*

- ☐ Occupational Therapist
- ☐ Physiotherapist
- ☐ Speech Language Clinician

The purpose of clinical involvement is to determine the needs of the child and to prioritize program options and services for the child and the family. At this time, there are some concerns regarding his/her overall development including:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

The above findings support the need for a development al assessment through the Child Development Clinic. As this clinic requires a physician's referral, I am requesting that this referral be completed through your office. The family is aware of and in agreement with this referral request.

Attachments may include:

*Check appropriate boxes:*

- ☐ Clinical report(s)
- ☐ Referral to Brandon Outreach Child Development Clinic prepared for signature
- ☐ Other: ___________________________________

Thank you for fulfilling this request in a timely manner. If you require additional information, please contact me at : _____________________________

Completed referrals may be forwarded to: Child Development Clinic
206-304-9th Street
Brandon, Mb. R7A 6C2