EXTENDED THERAPY SERVICES
Outreach Therapy
4325 Neill Street, Port Alberni, B.C. V9Y 1E5
Phone: 250-723-1117 / Fax: 250-723-7349

REFERRAL

Referral Date: _____
DA / MO / YR

Child's Name: _____ Sex: _____ Birth: _____
LAST, First **DA / MO / YR**

Parent(s) / Foster Parent(s): _____

Mailing Address: _____

Postal Code: _____ Telephone: (Home) _____ (Work) _____

Email: _____

Legal Guardian(s): _____ ☐ USMA ☐ MCFD

Family Doctor: _____ _____

Service requested: ☐ Occupational Therapy ☐ Physiotherapy ☐ Early Childhood Mental Health

☐ As offered under the Autism program for children who are over 6 years of age *These services are offered by a RASP certified therapist.*

☐ For school-aged children who qualify for the At-Home Program or other funding

☐ Other funded assessments and treatment

Reason for Requesting Service:

_____

_____

_____

What has been done so far to address these concerns? _____

_____

_____

Referred by: _____ Position: _____

Address: _____

Telephone: _____ Information Taken By: _____