MUSHKEGOWUK COUNCIL ᐅᒪᐡᑫᑯ ᐅᑭᒪᐃᐧᐃᐧᐣ

Special Needs Strategy Referral Form

MUSHKEGOWUK HEALTH
Okimawiwin Minopimatisiwinik Atoskawikamik

PARENT/LEGAL GUARDIAN MUST CONSENT TO REFERRAL

CHILD'S INFORMATION				
Last Name:		First Name:		
D.O.B.:______________________ DD/MM/YYYY	Age:	Gender: ☐ M ☐ F ☐ Other		
Address:		Apt/Unit:	Community:	Postal Code:

FAMILY INFORMATION	
Parent/Guardian Name: Relationship: Address: Primary Contact Number: Alternate Phone: Email:	Parent/Guardian Name: Relationship: Address: Primary Contact Number: Alternate Phone: Email:
Individual resides with: ☐ Both parents ☐ Mother ☐ Father ☐ Other: ________________________________	

REASON FOR REFERRAL	
Please select which services you are submitting a referral for:	
☐ Fetal Alcohol Spectrum Disorder ☐ Jordan's Principle ☐ Respite ☐ Funding Applications	☐ Rehabilitation ☐ Ontario Autism Program ☐ Other: ________________________
Please describe your concerns:	

Name of individual submitting the referral: ____

Agency/Relationship to Child: ____

Address:____

Phone: ____________________________ Email: ________________________________

☐ I CONFIRM THAT THE PARENT/GAURDIAN IS AWARE AND AGREES TO THIS REFERRAL

______________________________ Signature ______________________________ Date

______________________________ Printed Name

THE COORDINATED SERIVCE PLANNING COORDINATOR WILL CONTACT FAMILY BY TELEPHONE ONCE REFERRAL IS RECEIVED.

REFERRALS CAN BE SENT BY MAIL, FAX OR IN PERSON TO THE ADDRESS BELOW:
Mushkegowuk Health O.M.A. PO Box 370, Moose Factory, ON P0L 1W0
Ph: 705-658-4222 ext 161, TF: 1-800-265-6807, Fax: 705-268-0435, sns@mushkegowuk.ca