

Childhood Public Health Services Referral

Please complete all sections of this form.

Referral Date (dd/mm/yyyy)	Child's Last Name	Child's First Name	Personal Health Number
Date of Birth (dd/mm/yyyy)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Home Language	Is an interpreter needed? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, one will be provided at no cost
Parent/Guardian (last name, first name)		Parent/Guardian (last name, first name)	
Address			Postal Code
Daytime Phone Number	Other Phone Number	E-mail Address	

Other Service Providers

Family Doctor	Preschool/Daycare (if applicable)
Other Services Involved	

Description of Concern

Services Requested (for families living in Richmond only)

Consultation	<input type="checkbox"/> Hearing:	birth to 19 years
	<input type="checkbox"/> Public Health Nurse:	6 weeks of age to kindergarten eligibility
	<input type="checkbox"/> Speech and Language:	birth to kindergarten eligibility
Dental Services	<input type="checkbox"/> Dental Screening :	birth to 5 years
	<input type="checkbox"/> Treatment Resources:	birth to 18 years
Nutrition Workshop	<input type="checkbox"/> Starting Solid Food:	3 – 12 months
	<input type="checkbox"/> Helping Your Child Eat Well:	1 – 5 years and not eating well

Does the parent/guardian agree with this referral? Yes No (Parent/guardian consent is required for services.)

Contact the following programs for their referral forms if needed:
 Prenatal and Postpartum Care: 1-855-550-2229 Family & Child Counselling Program: 604-233-3223

Referral Source

Name	Agency (if applicable)	
Phone Number	Address	Postal Code

Return Completed Form to: Richmond Public Health, Community and Family Health
 Fax: 604-244-5455 Mail/Drop off: 8100 Granville Avenue, Richmond BC V6Y 3T6