sunbeam
DEVELOPMENTAL RESOURCE CENTRE

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sunbeam
COMMUNITY & DEVELOPMENTAL SERVICES

CLIENT REFERRAL FORM

DATE RECEIVED: _____ **Client ID #:** _____

CLIENT INFORMATION

CLIENT'S NAME: _____
First Middle Last

DATE OF BIRTH: _____ **AGE:** _____ **SEX:** _____
(Month/Day/Year)

CLIENT'S ADDRESS: _____

_____

_____ **PHONE:** _____

CONSENTS Signed By: Client ☐ or Legal Guardian ☐

PARENT/GUARDIANS' NAME(S): _____

ADDRESS (if different from client's): _____

_____

CONTACT PERSON: _____

PRIMARY PHONE: _____ **ALTERNATE PHONE:** _____

EMAIL ADDRESS: _____

REFERRAL SOURCE (if other than parent)

Client/Parent/Guardian Permission Received to Facilitate this Referral: Yes ☐ No ☐
(if No, Referral can not be accepted)

Referred By: _____

Agency/Address: _____

_____ **Phone:** _____

CURRENT NEEDS AND GOALS:

DIAGNOSIS

Please check one of the following:

☐ **Intellectual Disability** ☐ **Autism Spectrum Disorder** ☐ **Both**

☐ **Meets eligibility criteria for adult services through Developmental Services Ontario (DSO)**

DIAGNOSIS MADE BY/POSITION: _____

☐ **Assessments/Reports confirming eligibility are attached.**
(Please note that we cannot process this referral without documentation verifying eligibility.)

PLEASE INDICATE ALL SUPPORTS/PROGRAMS CURRENTLY BEING ACCESSED/REFERRED TO:

☐ **Access2 Card**	☐ **ACSD**	☐ **Disability Tax Credit (DTC)**	☐ **Disability Travel Card**
☐ **Easter Seals Incontinence Grant**	☐ **Front Door/ Carizon**	☐ **GRT Card**	☐ **KidsAbility**
☐ **KW Habilitation**	☐ **Ontario Autism Program (OAP)**	☐ **PAL Card**	☐ **Special Services at Home (SSAH)**

FOR REFERRALS FACILITATED BY KIDSABILITY

This Referral is for Resource Support Only ☐ **Yes** ☐ **No**
(If **Yes,** child will be registered with SDRC and family is to contact SDRC for Resource Support when needing help)

FOR OFFICE USE ONLY

Intake/Referral Date: _____