CHILDREN'S THERAPY PROGRAM

Referral For:

- Early Childhood Psychology
- Speech Language Pathology
- Occupational Therapy
- Physical Therapy

Send All Children's Therapy Program Referrals to:

Cornerstone Therapies Department
200 Bradbrooke Drive, Yorkton, SK S3N 2K5
(T) (306) 786-0178 (F) (306) 786-0179

DATE:			
LAST NAME	**FIRST NAME**	**MIDDLE INITIAL**	☐ **MALE** ☐ **FEMALE**
ADDRESS	**POSTAL CODE**	**EMAIL ADDRESS**	
HOME PHONE #	**WORK PHONE#**	**CELL PHONE #**	
DATE OF BIRTH	**AGE AT REFERRAL**	**PHYSICIAN NAME**	
PRIMARY CAREGIVER NAME(S)		☐ **Parent** ☐ **Guardian**	☐ **Foster Parent** ☐ **Other**
PERMISSION FOR THIS REFERRAL HAS BEEN GRANTED:		☐ **Yes**	☐ **No**
NAME OF PRESCHOOL, DAYCARE, ETC.		**PERSONAL HEALTH #**	

DIAGNOSIS / ASSOCIATED CONDITION(S): _____

CONCERN(S) / RELEVANT HISTORY: (must be completed for referral to be accepted)

LIST OF OTHER AGENCIES, IF ANY, WHICH HAVE PROVIDED SERVICE TO THIS CHILD:

Applicable reports attached ☐

REASON FOR REFERRAL: (please complete with the family)

- ☐ Mispronounces speech sounds
- ☐ Comprehension (child has difficulty understanding others)
- ☐ Limited use of words
- ☐ Stuttering
- ☐ Feeding/Eating
- ☐ Social interaction
- ☐ Fine Motor (small muscle & hand use)
- ☐ Gross Motor (large muscle development)
- ☐ Plagiocephaly or Torticollis
- ☐ Attention / Concentration
- ☐ Visual / Perceptual
- ☐ Self –care
- ☐ Sensory Issues
- ☐ Seating / Special Equipment
- ☐ Infant Motor Development
- ☐ Behavior / Cognitive
- ☐ Early Childhood Psychologist
- ☐ Other: _____

REFERRAL SOURCE: (This must be completed prior to sending the referral)

NAME (PRINT OR TYPE)	SIGNATURE	
ADDRESS	POSTAL CODE	TELEPHONE NUMBER
RELATIONSHIP OF REFERRAL SOURCE TO CHILD		