Corporation of the County of Bruce
Human Services Department
30 Park St., P.O. Box 399, Walkerton, ON N0G 2V0

childcare@brucecounty.on.ca
Toll Free: 800-265-3022
Fax: 519-881-4324

Special Needs Resource Referral Form

Child's Name: _____ _____ **Date of Referral:** ____/____/____
First Name Surname DD MM YY

Child's Date of Birth: ____/____/____ **Child's Gender:** _____
DD MM YY

Parent/Guardian: _____ **Phone:** _____
_____ **Email:** _____

Address: _____ _____ _____ _____
Number Street Town Postal Code

Centre name: _____

Educator(s) name: _____

Program: ☐ Infant ☐ Toddler ☐ Preschool ☐ Recreational Program/Camp ☐ EarlyON ☐ Licensed Home Child Care

Schedule: ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

Child's Strengths:

Concerns:

☐ **Exploration**

- Exploration around child's needs
- Strategies and Recommendations
- Up to 6 visits consultation

☐ **Intensive**

- Further Screening and Assessment and the results will be explained to me
- Individual Support Plan Developed with family and educator input
- Goals and Strategies
- Sharing and receiving information regarding my child's development
- School Transition as per protocol
- Team Based Collaboration with Service Providers (OT, SLP, PT)

I understand that my child will be seen by Bruce County Special Needs Resource Program for service. I understand the information is confidential and I am aware that I can discontinue service/consent at any time.

Parent /Guardian: _____ Date: _____

Please email completed form to childcare@brucecounty.on.ca