Request for Service

Pathways Health Centre for Children
Rotary Place
1240 Murphy Rd. Sarnia ON N7S 2Y6
Tel: (519) 542-3471
Fax: (519) 542-4115
www.pathwayscentre.org
info@pathwayscentre.org

File #

DATE OF REQUEST: _____ **Name of person completing request:** _____

Pathways is happy to accept referrals from a variety of sources. Your relationship to this client is:

☐ Self ☐ * Teacher/School ☐ * Doctor/Nurse Practitioner
☐ Parent ☐ * Licensed Childcare ☐ * Partner Agency: _____
☐ Legal Guardian ☐ * Other (please explain): _____

**** If the referral is not from self/parent/legal guardian, it is the expectation that the parent/custodial caregiver is in support of this referral. This referral has been discussed with the family:*** ☐ YES ☐ NO

CLIENT IDENTIFICATION:

Client's Name (Last, First, Initial)	Date of Birth YR / MO / DAY	Gender or preferred pronoun
Address		

Postal Code	Primary phone number	Secondary phone number	E-mail

Client's Doctor/Nurse Practitioner	Language Spoken at Home
Preschool and/or School (current or if not yet in school, where will they attend)	

PARENT / CUSTODIAL CAREGIVER IDENTIFICATION:

Name	Relationship to client	Address (if different from above)
Primary phone number	Secondary phone number	E-mail
Name	Relationship to client	Address (if different from above)
Primary phone number	Secondary phone number	E-mail

IF REFERRAL IS NOT FROM SELF/PARENT/LEGAL GUARDIAN, PLEASE COMPLETE THE FOLLOWING:

Your Name	Your Title
Name of Your Organization/Agency	Your Contact Phone Number

PLEASE DESCRIBE YOUR REASON FOR REQUESTING SERVICE AT PATHWAYS:

Does the family wish to identify itself or this client as: ☐ First Nation ☐ Métis ☐ Inuit ☐ Other: _____

SERVICE REQUESTED:

☐ Audiology ☐ Augmentative Communication ☐ Autism Diagnostic Hub
☐ Feeding Services ☐ Fetal Alcohol Spectrum Disorders Resource ☐ Occupational Therapy
☐ Physiotherapy ☐ Resource Support in Licensed Childcare ☐ Seating and Mobility
☐ Speech-Language Pathology ☐ Therapeutic Recreation Services ☐ TR Teen Transition