COMMUNITY LIVING
Kincardine and District
Inspiring Possibilities

Infant and Child Development Referral Form

Please complete this form and return it to CLKD's Infant and Child Development Worker, Jenny by fax at 519-396-4514 or e-mail at jraspberry@clkd.ca, or by dropping it off in person at our office at 286 Lambton Street.

Date of referral: ___________________________

Name of child: ____________________________ Date of Birth: ____/____/____
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Name of Person making referral: ____

Are you the Parent or are you making the referral on behalf of the family?

Parent ☐ Making referral on behalf of the family ☐

If you are making the referral on behalf of the family, what is your Agency name and your position within the Agency?

____

Has the parent(s) been informed of the referral? Yes ☐ No ☐

Parent/guardian name: ____

Parent/guardian address: ____

Reason for referral:

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How would you like us to contact you about this referral:

☐ Phone: _______________________ ☐ Email: _______________________________

For Agency Use Only

Received by CLKD Staff member: ____________________________________
(Name of Staff member)

Date: ___________________________