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REQUEST FOR SERVICE

Date: _____

Is the parent/legal guardian aware of this request? Yes [] No []

Child's Name: _____ Date of Birth: _____
Day/Month/Year

Care Card Number: _____ Gender: M F Aboriginal/Metis Yes [] No []

Does the family need an interpreter? Yes: ___ No: ___ Language: _____

Parent/Guardian: _____

Address: _____ Phone:(H) _____

_____ Cell Phone: _____

_____ Phone:(W) _____

E-mail Address _____

Physician: _____

Source of request (name): _____ Phone: _____

Name/Organization: _____

Are there any cultural or religious observances of which we should be aware? _____

Reason for request/main concern: _____

Parent/Guardian's Signature: _____

CDC OFFICE USE

Intake Information

(THIS INFORMATION IS USED FOR ELIGIBILITY)

CDC DISCHARGE FILE Yes [] No []

Child's Name: _____

Date of Birth: _____
Day/Month/Year

Team: _____

Date: _____

Discussion notes:

Plan following discussion:

Assigned to team member(s) for initiation of Individual Service Plan (ISP)

CYC: _____ SCD: _____ FASD: _____

ISSP: _____ PFSP: _____ PT: _____

IDP: _____ SLP: _____ OT: _____

When: _____

Assigned to group _____

Assigned to fee for service _____

Recommend further information from referral source or parent

Who: _____

When: _____

Recommend referral to another organization

Where: _____

Who: _____

When: _____

Next Steps for Assigned Team member(s):

Follow up with client for initiation of Individual Service Plan (ISP)

Stat entry in Electronic Client Record