Kids Pathways Peel Coordinated Service Planning (KPP CSP)

COMMUNITY REFERRAL FORM

For agencies, organizations and professionals making referrals on behalf of a family. Families may also self-refer by calling 905-890-9432. KPP CSP is available to families of children and youth with special needs up to age 18 years of age or to age 21, if still in school, and:

- The family requires assistance navigating supports and/or services.
- The family is involved with multiple agencies and would benefit from coordinated service planning.

Referral instructions

- Please complete this referral form and obtain signed consent from the parent/guardian.
- **With the family's consent**, please attach any relevant medical or psychological documentation confirming the child's diagnosis. This helps reduce the burden on families during intake.
- **With the family's consent**, **Kids Pathways Peel Intake** may contact you, if they are unable to reach the family.
- Email the completed form (and documents, if applicable) to: **info@kidspathwayspeel.com.**
- Intake staff will contact the family to make an intake appointment.
- For more information, call 905-890-9432 (TTY: 905-890-8089; Caledon: 1-888-836-5550).

REFERRAL AGENCY INFORMATION

Agency name:

Name of caller:

Phone:

Email:

Reason for referral:

☐ Service coordination

☐ E-blast

CHILD/YOUTH INFORMATION

First name:

Last name:

Date of birth (DD/MM/YYYY):

Gender: ☐ male ☐ female ☐ other

Has the child/youth's diagnosis been confirmed?

☐ Yes ■ No

Primary diagnosis:

Secondary diagnosis (if applicable): fill box

FAMILY NEEDS/CONCERNS (GOALS)

(Briefly describe why the family is being referred and what support they are seeking.)

SERVICES THE FAMILY IS ALREADY CONNECTED WITH

PARENT/GUARDIAN INFORMATION:

Primary contact name:
Relationship to child:
Best time to call:

Address:
City:
Postal code:

Primary phone:
Secondary phone:
Email:

May we contact the family by email?
☐ Yes ☐ No

Is an interpreter required, provided by CDRCP?

☐ Yes ☐ No

Language(s) spoken in the home:

PARENT/GUARDIAN CONSENT

☐ *I consent for the referring agency to make a referral to* Kids Pathways Peel CSP *and give permission to* Child Development Resource Connection Peel (CDRCP)*, on behalf of* Kids Pathways Peel CSP n*etwork to follow up with the referring agency to:*

- *obtain clarification of information provided, if needed, and*
- *request assistance to connect with me, if* CDRCP *is unable to make contact*

☐ *I give permission for the referring agency to share copies of my child's medical or psychological assessment(s) with* Kids Pathways Peel CSP*. I understand that this information will be used only for intake and service coordination within* Kids Pathways Peel CSP *network.*

Signature of parent/guardian: _____
Date (DD/MM/YYYY): _____