Infant and Toddler Development Program

Referral Form

Please Print

Date of Referral:_____ Parent Consents to Referral: Y ☐ N ☐

Child's Name: _____ Sex: M ☐ F ☐

Date of Birth: _____ E.D.C. _____

Parent's/Caregiver's Names: _____

Telephone: Home _____ Cell _____ Work _____

Address: _____ Postal Code: _____

Family Physician: _____

Pediatrician: _____

Other Health Care Provider/Agency: _____

Reason for Referral: _____

_____

_____

_____

Other information: _____

_____

_____

_____

A copy of the child's medical history would be helpful.

Referral Source: _____

Please send referral to:

Infant and Toddler Development Program
Peterborough Public Health
Jackson Square, 185 King Street
Peterborough, ON K9J 2R8
705-743-1000 ext. 282
705-741-4261 (fax)