**CHILD LIFE – REFERRAL - INTAKE FORM**

 **Please email completed form to** **ChildYouthTherapeuticServicesAdmin@cw.bc.ca**

**Intake**

**n**

Is this request part of a **RESEARCH STUDY? YES** [ ]  **NO** [ ]

If yes, please contact Gloria Kwong.

 *Child Life Specialists are unable to support research studies as part of their positions. If you would like more information or to discuss funding support for this request, please contact* **ChildYouthTherapeuticServicesAdmin@cw.bc.ca**

***Research Study Name****:* Click here to enter text.

***Contact Info****:* Click here to enter text.

**Reason for Referral:** Click here to enter text.

**Area/Unit Patient will be visiting:** Click here to enter text.

**Referral Made By** Click here to enter text.

**Referee Contact Number** Click here to enter text.

**Patient Name** Click here to enter text.

**Date of Birth** Click here to enter text.

**MRN/PHN** Click here to enter text.

**Caregivers Name(s)** Click here to enter text.

**Contact Number(s)** Click here to enter text.

**Patient Hometown** Click here to enter text.

**Underlying Health Condition** Click here to enter text.

**Existing appointment** [ ]  YES [ ]  NO
**Appointment Time & Date:** Time: \_\_\_\_\_\_  Click here to enter a date.

**Urgency** [ ]  emergent – today [ ]  within 48 hours [ ]  within 1 week [ ]  > 1 week

**Date of Request:** Click here to enter a date.

Click here to enter text.

**Notes**