Children's Aid Society
La Société d'aide à l'enfance
NIPISSING & PARRY SOUND

Community Action Program for Children - CAPC

REFERRAL FORM

Date of Referral:		**Name:**	
Date of Birth: (dd/mm/yyyy)		**Address:**	
MARITAL STATUS: ☐ **Single** ☐ **Married** ☐ **Divorced**		**If pregnant, Due Date:**	
Telephone Number:		**Cell Number:**	
email:			
Currently Parenting: ☐ **Yes** ☐ **No**	**Number of Children:**		
Child's Name: **(Last Name)**	**(First Name)**	**Identified Gender:**	
Child's Date of Birth:			
Person Referring:		**Agency Name/Other:**	
Position:		**Telephone:**	
Participant's Signature:			

By signing the above I hereby consent to share my client information, and that of my child, with the referent listed on this form and the Community Action Program for Children. I also understand and consent that my service information may be used for the purposes of research and evaluation provided that the information used in such manner meets the tri-council ethical requirements and is non-identifiable. I understand that my consent may be revoked at any time by submitting a request in writing to the Supervisor of the CAPC program.

Referent or Client Comment(s):

Please FAX to: 705-667-0280 or
Email: earlyinterventionservices@parnipcas.org