CONFIDENTIAL

Sioux Lookout First Nations Health Authority

DEVELOPMENTAL SERVICES

SERVICE APPLICATION (EXTERNAL)

(0-17 YEARS 364 DAYS)

This **external** form is for caregivers, educators, and others to request Developmental and allied pediatric services. SLFNHA and other service providers should use the **Service Application (Internal)** form.

Fax completed forms to (807) 737-3734 (can be given to Nursing Station).

Child/Youth

Date of birth: Year: _____ Month: _____ Date: _____

Name: Last: _____ First: _____

Preferred name: _____ Pronouns: _____

Community & address: _____

Registration numbers: Band: _____ Health card:_____ Mustimuhw: _____

Guardians/Caregivers

Guardian(s): Name(s): _____ Relationship: _____

Phone number(s): (_____)-_____-_____ (_____)-_____-_____

Mailing address: _____

☐ Check if guardian is also a primary caregiver (skip the rest of this section)

Caregiver(s): Name(s): _____ Relationship: _____

Phone number(s): (_____)-_____-_____ (_____)-_____-_____

Mailing address: _____

CONSENT (REQUIRED)

I CONSENT TO THE RELEASE OF THIS CHILD/YOUTH'S PERSONAL AND HEALTH INFORMATION IN ORDER TO REQUEST SERVICES THROUGH SLFNHA DEVELOPMENTAL SERVICES AND ITS CONTRACTED SERVICE PROVIDERS

☐ **I AM A LEGAL GUARDIAN**

☐ **I HAVE RECEIVED VERBAL OR WRITTEN CONSENT FROM A LEGAL GUARDIAN**

Your name: _____

Relationship to child/youth: _____

Phone number(s): (_____)-_____-_____ (_____)-_____-_____ (_____)-_____-_____

Signature: _____

Date: Year: _____ Month: _____ Date: _____

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Client/Youth name: _____ **Date of birth:** _____

Reasons for requesting services

We reserve the right to direct the client to the most appropriate initial services based on the information provided which may not be a SLFNHA service

What is the child/youth's **story**? What are you **concerned** about (e.g., at home, school, day care)?

What is or has already been done to **help**?

Is there anything else we should **know**?