NWT Disabilities Council
Respite Program
Referral Form

Child/Youth Name: _____ Age: _____

Identification#: _____

Community: _____

Referral Completed By: _____

Relationship to child/youth or Position: _____

Is the parent/ legal guardian aware of the referral and in agreement that NWTDC contact them?

Yes___ No___ If no, why? _____

Does this child/youth live with their parent/legal guardian?

- ☐ Yes
- ☐ No

Legal Guardian's name: _____

Contact #: Day _____ Evening:_____ Cell: _____

What type of delay/ disability is the child/youth living with? Please check all that apply

- ☐ Physical _____
- ☐ Cognitive _____
- ☐ Sensory _____
- ☐ Psychiatric _____
- ☐ Intellectual _____
- ☐ Learning _____

Is this disability:

- ☐ Diagnosed
- ☐ Suspected

Name of Physician/Medical Professional _____

Official Diagnosis _____

Other Comments:

_____

_____

_____

_____

Signature of Individual Referring the family:

_____

**Please email back to csm@nwtdc.net, or fax to 1-867-873-4124.

Thank you very much for your time. If you have any questions or further comments, please contact:

Children's Services Manager

NWT Disabilities Council

1-888-873-8231

1-867-873-8230

www.nwtdc.net