NWT Disabilities Council

Respite Coordinator
rsp@nwtdc.net

Community Respite Program
Referral Form

Name of Child: _____ Age: _____

Address: _____

Name of Parent/Legal Guardian: _____

**Please note that children in foster care are not eligible for respite service*

Name of Referring Individual: _____

Is parent/guardian aware of referral? Yes_____ No _____

Agency: _____ Position: _____

Date of Referral: _____

Reason for Referral

What type of disability does the child/youth have? (Check all that apply)

***Does not have to be diagnosed*

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

Disability is:

- ☐ Diagnosed
- ☐ Suspected

Please give a description of the child/youth you are referring:

_____
_____
_____
_____

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Please identify the reasons why you believe the family qualifies for/will benefit from respite service:

_____
_____
_____
_____

Other comments:

_____
_____
_____

Signature of individual referring the family: _____