

LANARK COMMUNITY PROGRAMS
FAMILY RELIEF PROGRAM
Unit 1, 30 Bennett Street, Carleton Place, Ontario K7C 4J9
257-7619 or 1-866-257-7618
Fax: 257-2209

FAMILY RELIEF PROGRAM REFERRAL

Child's Name: _____ **DOB:** _____ **Age:** _____ **HC#:** _____
Mother's Name: _____ **DOB:** _____ **Sin#:** _____ **HC#:** _____
Father's Name: _____ **DOB:** _____ **Sin#:** _____ **HC#:** _____
Home Phone: _____ **Cell:** _____ **Mom's Work:** _____ **Dad's Work:** _____
Address: _____
Email Address: _____ **Income/Year \$** _____ **ACSD** ☎ **SSAH** ☎
Referred By/Phone #: _____ **Signature:** _____ **Date:** _____

Medical: (diagnosis/severity of condition; diagnosing physician; medications; behaviours in school/home; other special needs kids)

Reason for referral: (parents state of health/mental health, employment/marital status, # dependants, names/d.o.b., concerns)

Involvement with: (other agencies; doctors/schools; previous ACSD/SSAH funding)

Relief needed: (respite, relief worker, tutor, social/therapeutic/daycare/summer program, medical related expenses)

Recommendations: (referrals made; actions taken; appointment preference ie. day/evening; home/office)

