WTCI Education Department
www.wtci.wolastoqey.ca
(506) 459-6341

REFERRAL FORM

CLIENT INFORMATION				
Date of Referral: (MM/DD/YYYY)		**Community:**		
Child/Youth Name:				
Date of Birth: (MM/DD/YYYY)		**Age:**		
Gender:	☐ Male ☐ Female	☐ Two-Spirit ☐ Intersex	☐ Transgender ☐ Prefer Not to Say	☐ Other:
Status Card Number:				
Address:				
Parent/Guardian(s):				
Phone Number(s):	Preferred:	Other:		
Email Address:				
School/Daycare:				

Describe Area(s) of Concern Below:			
☐ Social/Emotional ☐ Behavioural ☐ Speech and Language	☐ Motor Skills ☐ Sensory Processing ☐ Play Skills	☐ Impulsivity ☐ Flight Risk ☐ Feeding/Diet	☐ Mental Health/Self-Esteem ☐ Toileting Skills ☐ Sleep

Does the Parent/Guardian Share These Concerns?	☐ Yes ☐ No	**Date Discussed with Parent/Guardian:**
Is the Parent/Guardian Aware of this Referral?	☐ Yes ☐ No	**Date Discussed with Parent/Guardian:**
Name/Agency of Person Referring:		
Phone Number:		
Email Address:		

Please submit a copy to our confidential email: WTCIeducation@wolastoqey.ca

Last updated November 24, 2025