INTAKE REQUEST

Date _____ **Referred by (if applicable)** _____

Child's Name _____ / _____
(first name) (last name)

Date of Birth _____ / _____ / _____
(month) (day) (year)

Mother's Name _____ / _____
(first name) (last name)

Father's Name _____ / _____
(first name) (last name)

Home Address _____

City _____ Prov _____ Post Code _____

Telephone (H) _____ (W) _____ Cell _____

Email _____ Fax _____

How did you hear about us?

Advertisement	Other Health Professional
CLSC	Pediatrician
Hospital	Website
Newsletter	Word of Mouth

2. What are your concerns and needs?

_____

_____

_____

3. If your child has been given a diagnosis, please give details:

_____

Return form to: intake@yaldei.org or by fax (attention Dina Davis): 514-278-3666