CONFIDENTIAL

Sioux Lookout
First Nations
Health Authority

PEDIATRIC SERVICES
SERVICE APPLICATION (EXTERNAL)
(0-17 YEARS 364 DAYS)

This **External** form is for caregivers, educators, and other community programs to request pediatric services for a child/family. SLFNHA and other service providers should use the **Internal** form.

Please note the application will be triaged to the most appropriate service(s) based on the information provided.

Child/Youth

Date of birth: Year:_____ Month:_____ Day:_____

Name: Last:_____ First:_____

Preferred name:_____ Pronouns: _____

Community & address: _____

Registration numbers: Band:_____ Health card:_____ Mustimuhw: _____

Guardians/Caregivers

Guardian(s): Name(s):_____ Relationship:_____

Phone number(s): (_____)-_____-_____ (_____)-_____-_____

Mailing address: _____

☐ **Same as above** (check box, skip the rest of this section)

Caregiver(s): Name(s):_____ Relationship:_____

Phone number(s): (_____)-_____-_____ (_____)-_____-_____

Mailing address: _____

<mark>I CONSENT TO THE RELEASE OF THIS CHILD/YOUTH'S PERSONAL AND HEALTH INFORMATION IN ORDER TO REQUEST SERVICES THROUGH SLFNHA DEVELOPMENTAL SERVICES AND ITS CONTRACTED SERVICE PROVIDERS.</mark>

    ☐ **I AM A LEGAL GUARDIAN**

    ☐ **I HAVE RECEIVED VERBAL OR WRITTEN CONSENT FROM A LEGAL GUARDIAN**

Referring Party

Referring Party Name: _____

Relationship to child/youth: _____

Phone:(_____)-_____-_____ ☐Preferred

Fax:(_____)-_____-_____ ☐ Preferred   Signature: _____

Email:_____ ☐Preferred   Date: _____

Fax completed forms to (807) 737-3734 (can be given to Nursing Station).

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Client/Youth name:	**Date of birth:**

Reasons for requesting services
Note that we reserve the right to direct the client to the most appropriate initial services based on the information provided

What is the child/youth's **story**? What are you **concerned** about (e.g., at home, school, day care)?

What is or has already been done to **help**?

Is there anything else we should **know**?

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