CONFIDENTIAL

Sioux Lookout First Nations Health Authority

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

This form is for SLFNHA and other service providers to request pediatric services for a child/family.
***Please note the application will be triaged to the most appropriate service(s) based on the information provided. This may include deferring to community-based programs if appropriate.***

**(REQUIRED) Verbal Consent: ☐ LEGAL GUARDIAN ☐ MATURE MINOR** **Referring Party Initials:_____**

## Child/Youth

**Date of birth:** Year:_____ Month:_____ Date:_____

**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: _____

## Referring Party

Your name:_____ Title/role:_____

Phone:(_____)-_____-_____ ☐Preferred

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

Email:_____ ☐Preferred Date: _____

**Pediatric Services (0-18) may include:**

- Audiology
- Behavioural Support
- Complex Care Navigation
- Developmental Pediatrics
- Dietician Services
- FASD Diagnostic Clinic
- Foot Care
- Indigenous Liaison (Traditional Services)
- Infant and Child Development Support
- Occupational Therapy
- Optometry
- Physiotherapy
- Pharmacy
- School and Clinical Psychology
- Speech Language Support

***Please direct SLFNHA-requested applications for non-developmental related Psychiatric services, Psychology services, Mental Health supports and Counselling to:*** **Nodin Mental Health Services, using their referral form(s).**

Sioux Lookout First Nations Health Authority

PEDIATRIC SERVICES

# SERVICE APPLICATION (INTERNAL)

(0-17 YEARS 364 DAYS)

This form is for SLFNHA and other service providers to request pediatric services for a child/family.

***Please note the application will be triaged to the most appropriate service(s) based on the information provided. This may include deferring to community-based programs if appropriate.***

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

## Application details

| **Support(s) Requested** | **Detailed** reasoning for requested support(s)<br>Please include supporting documentation as appropriate. |
|---|---|
| 1. | 1. |
| 2. | 2. |
| 3. | 3. |
| 4. | 4. |
| 5. | 5. |

**Relevant current management** (e.g., therapy, medication, lab work, diagnostic imaging):

**Additional considerations/information** (e.g., language barrier, child protection, sensory/behaviour challenges):

***Please attach relevant documentation if not already in Mustimuhw***