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REFERRAL FORM

Today's Date: _____

First Name: _____ Last Name: _____

DOB: _____ Male Female

Name of the person making referral: _____

Relationship to child: _____

Has the parent/guardian been informed of this referral: Yes No

Name of caregiver(s) _____ Foster Parent

_____ Foster Parent

Name of legal guardian (if different from above): _____

Mailing Address: _____

Street Address: _____

City: _____ Postal Code: _____

Phone: _____ Work: _____ Cell: _____

Best time to call: am pm other: _____

Reason for the referral: _____

Referral from: Kwanlin Dun Health Centre Whitehorse Health Centre

Childcare program: No Yes Name of program: _____

Name of Doctor: _____ YHCIP#: _____

Office Use Only

File #: _____ Date Entered: _____

Referral assigned to: _____

Comments: _____