Updated December 2015

HealthUnit
Haldimand-Norfolk

Car Seat 3rd Party Referral

Please fax referral form to 905-765-8905
For further information call 905.318-6623 Ext. 3371 or 519-416-6170 Ext. 3371

Date of Referral _____ Referral Agency _____

Staff Contact Name _____ Telephone # & Ext _____

Fax _____ Email _____

Client's Name _____ DOB (dd/mm/yy) _____

Street Name _____ Apt. or R.R. # _____

Town _____ Postal Code _____

Telephone _____ Is client receiving Social Services/ODSP? ☐ Yes ☐ No

Number of children in the family _____ Ages of children _____

What other agency in the community is the family involved with? eg. CAS, NPCC, HPCC etc _____

For Social Services Referrals Only:
I consent to the information being exchanged with a Social Services delivery agent and the Injury prevention Program of the Haldimand-Norfolk Health Unit for the purposes of referral with the Car Seat Donor Program.
I further give consent for acknowledgement of being currently eligible for Social Services.

_____ _____

Signature of Referral Source Signature of Applicant

Number of children aged 0-6 for whom a car seat donation is requested:

Child's Name	Age	DOB (dd/mm/yy)	Weight (lbs)	Height (inches)

I confirm that I maintain an active supporting relationship with this client and to the best of my knowledge she/he:

1. Has investigated all other possible resources to acquire a seat. ☐ Yes ☐ No
2. Owns a vehicle. ☐ Yes ☐ No Make _____ Model _____ Year _____

OR Has access to a vehicle they use regularly. ☐ Yes ☐ No Make _____ Model _____ Year _____

3. Has/will have the appropriate number of tether bolts installed prior to the appointment. ☐ Yes ☐ No ☐ N/A
4. Will have the vehicle at the appointment. ☐ Yes ☐ No
5. Has agreed that she/he will attend the appointment and that the child(ren) for whom the seats(s) is/are intended will be there as well. ☐ Yes ☐ No
7. Is experiencing financial hardship. ☐ Yes ☐ No

Additional Comments:

_____

Signature of Referral Source

For Health Unit Use:

Request approved: ☐ Yes ☐ No Date referral source notified _____ Date of appointment _____

Completed by _____ No. of seats installed _____

Make/Model of seat(s) provided _____

Additional Comments:

_____

Signature of Health Unit Staff