**Resource Consultation Request**

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| Request Date: | | |
| Program Name: | | Classroom: |
| Supervisor’s Name: | | Program Address: |
| Program E-mail: | | Program Phone: |
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| ***The intent of a Resource Consultation is to provide a goal specific service (up to 3 visits)***  \*A Resource Specialist will be in contact with you. Please be prepared to discuss the reason for the request and a specific goal that you want to achieve. | | |
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| Program Consultation  This consultation will guide and support staff, support knowledge transfer and help all children participate in your program. | Child Specific Brief Consultation (Parental Consent)  Parent Consent  See website below for consent form  ***http://www.peelregion.ca/children/working/service-providers/index.htm*** | |

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| For Office Use Only |
| Date Received:  Date of Initial  Date of Scheduled Consultation: |

**Please send the completed form to** [EarlyYearsSystemDivision@peelregion.ca](mailto:EarlyYearsSystemDivision@peelregion.ca)