**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 ConsultationThis 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