South
Central
Early
Childhood
Intervention
Program

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Referral For
FAMILY CENTRED HOME BASED INTERVENTION SERVICES

Date: _____
(Month/Day/Year)

Parents/Guardians:
Address:
Postal Code:
Phone Number(s):
Email Address(es):

Child's Name:
Birthdate:
Age in months: **Gender:**
Sask. Health Number:
Treaty #: **Band:**

Referring Agent:
Agency:
Address:
Postal Code:
Telephone: **Fax:**

Length of Time Associated with Family/Child: _____

Frequency and Intensity of Contact: _____

Diagnosis: _____

Reason for Referral: _____

_____

_____

Describe family/child needs: _____

_____

_____

_____

Describe how you will collaborate with the Early Childhood Intervention Program for the family and the child (if the parents so choose):

_____

_____

_____

_____

Has this child been assessed?

	BY WHOM	**WHEN and WHERE**
Medical	_____	_____
Psychological	_____	_____
Speech	_____	_____
Physio	_____	_____
Occupational Therapy	_____	_____
Other (specify)	_____	_____
	_____	_____
	_____	_____
	_____	_____

Please list any other agencies or professionals presently involved:

Name	**Agency**	**Location**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I have _____ I have not _____ discussed my referral to the South Central Early Childhood Intervention Program with the parent(s)/guardian(s).

_____ _____

Signature of Referring Agent **Date**