West Central Early Childhood Intervention Program
Box 775, Kindersley, Sask. S0L 1S0
306-463-6822 Fax: 306-463-6898

REFERRAL FOR EARLY CHILDHOOD HOME BASED INTERVENTION SERVICES

Date: _____
(Day) (Month) (Year)

Child's Name: _____ _____ _____
(First) (Middle) (Last)

Sex: Male ☐ Female ☐ **Birth Date:** _____
(Day) (Month) (Year)

Age at Referral: _____

Parents / Foster Parents / Guardian: _____

Relationship to Child: _____

Address: _____ **Town:** _____

Box: _____ **Postal Code:** _____

Telephone: Home: _____ Work: _____

Referring Agent: _____ Agency _____

Address: _____

City: _____ Postal Code: _____

Telephone _____ Fax: _____

Length of time associated with child/family: _____

Frequency and intensity of contact: _____

Diagnosis: _____

Reason for Referral: _____

_____

_____

Describe Child/family needs: _____

_____

I have discussed my referral to the West Central ECIP with the parent (s) / guardians. Yes or No (please circle one)

_____ _____
(Signature of Referring Agent) (Date)