

KOOTENAY FAMILY PLACE

EARLY INTERVENTION SERVICES

REFERRAL FORM



767 11TH Ave, Castlegar, BC, V1N 1J7
 250-365-5616 ~ 1888-644-5616
Fax: 250-365-5792
 www.kootenayfamilyplace.org

REFERRAL DATE: _____

PARENT IS AWARE OF REFERRAL:

PLEASE CHECK OFF REQUESTED SERVICES	Supported Child Development Program (West Kootenay Boundary) <input type="checkbox"/>	Infant Development Program (Castlegar, Trail, Rossland, Nelson & areas & Slocan Valley to Nakusp) <input type="checkbox"/>
Physiotherapy (Castlegar and Trail) <input type="checkbox"/>	Occupational Therapy (Castlegar and Trail) <input type="checkbox"/>	Speech Therapy (Castlegar area & Nakusp area) <input type="checkbox"/>

CHILD/FAMILY INFORMATION:

CHILD: _____ DOB: _____ GENDER: _____

FOSTER CHILD: Yes No

ABORIGINAL HERITAGE: Yes No

PARENT/CAREGIVER: _____ Phone: _____

PARENT/CAREGIVER: _____ Phone: _____

Address: _____ City: _____ Postal: _____

House directions: _____ Email: _____

Safety Factors in home: _____

REFERRAL INFORMATION:

REFERRAL SOURCE: _____ PHONE: _____

For infants, only: Gestational Age: _____ APGARS: _____ Birth Weight: _____

REASON FOR REFERRAL (Please provide as much information as possible):

OTHER SERVICE PROVIDERS (ex. Pediatrician, Physiotherapist, GP):

OFFICE USE ONLY:

I have read the information above, it is correct, and I agree to service. I have received/reviewed the KFP Handbooks.

Parent/Guardian Signature: _____ Date: _____

KFP Service Provider: _____ Date: _____

Acceptance Date: _____

ON DATABASE