

## EARLY INTERVENTION SERVICES REFERRAL FORM

REFERRAL DATE: \_\_\_\_\_

PARENT CONSENTS TO REFERRAL:

PARENT GIVES CONSENT FOR KFP TO CONTACT REFERRAL SOURCE IN REGARD TO THIS 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: \_\_\_\_\_ DOB: \_\_\_\_\_ GENDER: \_\_\_\_\_

FOSTER CHILD:  YES  NO ABORIGINAL HERITAGE:  YES  NO

PARENT/CAREGIVER(1): \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Home/Work Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal: \_\_\_\_\_

House directions: \_\_\_\_\_ Safety Factors in home: \_\_\_\_\_

PARENT/CAREGIVER(2): \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Home/Work Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal: \_\_\_\_\_

House directions: \_\_\_\_\_ Safety Factors in home: \_\_\_\_\_

REFERRAL SOURCE: \_\_\_\_\_

PHONE: \_\_\_\_\_ EMAIL: \_\_\_\_\_

For infants, only: Gestational Age: \_\_\_\_\_ APGARS: \_\_\_\_\_ Birth Weight: \_\_\_\_\_

**REASON FOR REFERRAL:**

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