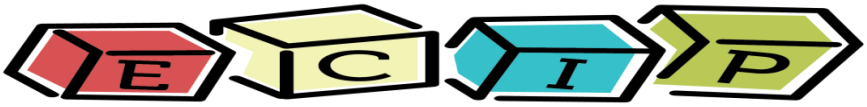
PARKLAND



Parkland Early Childhood Intervention Program
83 North Street Yorkton, SK S3N 0G9
Phone: 306-786-6988 **Fax**: 306-786-7116 **Email**: parklandecip@sasktel.net

Referral for Early Childhood Home Based Intervention Services

Date: _____

CHILD'S NAME: _____
(First) (Middle) (Last)

SEX: Male: ☐ Female ☐ **DATE OF BIRTH**: _____ **Age:** _____
(Day) (Month) (Year)

DIAGNOSIS (if applicable) _____

PARENTS/FOSTER PARENTS/GUARDIAN _____
(Circle one)
_____

ADDRESS: _____
(House #, Street name, Box #, City/Town, Postal Code)

HOME PHONE:_____ **CELL:** _____ **WORK**: _____

REFERRING AGENT:

NAME: _____**TITLE**: _____ **AGENCY**: _____

ADDRESS: _____

CITY: _____ **POSTAL CODE:** _____ **PHONE**: _____

FAX: _____ **EMAIL**: _____

LENGTH OF TIME ASSOCIATED WITH CHILD/FAMILY: _____

FREQENCY AND INTENSITY OF CONTACT: _____

REASON FOR REFERRAL: _____

_____

_____

DESCRIBE CHILD/FAMILY NEEDS: _____

_____

_____

_____

_____

Describe how you will collaborate with the Early Childhood Intervention Program in developing an Individualized Family Support Plan (IFSP) for the child and family.
(if the parents so choose).

_____

_____

_____

I have □ Have not □ discussed my referral to the **PARKLAND** ECIP with the parent(s)/guardian(s)

I have □ Have not □ given the parent(s)/guardian(s) an application form.

_____ _____

Signature of referring Agent Date