PRINCE ALBERT EARLY CHILDHOOD INTERVENTION PROGRAM, INC.
#201 1008 1st Avenue West
Prince Albert, SK S6V 4Y4
Telephone: (306) 922-3247
Fax: 763-5244 E-mail: paecip@sasktel.net

REFERRAL FOR EARLY CHILDHOOD INTERVENTION PROGRAM SERVICES

DATE:
_____
(Day) (Month) (Year)

CHILD? NAME: _____
(First) (Middle) (Last)

SEX: Male: ____ Female: ____

BIRTH DATE:
_____
(Day) (Month) (Year)

S.H.S/TREATY # _____ BAND _____

AGE AT REFERRAL:
_____

PARENTS / FOSTER PARENTS / GUARDIAN: _____

RELATIONSHIP TO CHILD: _____

ADDRESS: _____ POSTAL CODE: _____

PHONE: HOME: _____ WORK: _____ CELL: _____

REFERRING AGENT: _____

AGENCY: _____

ADDRESS: _____ POSTAL CODE: _____

TELEPHONE: _____FAX:
_____

LENGTH OF TIME ASSOCIATED WITH CHILD/FAMILY: _____

FREQUENCY AND INTENSITY OF CONTACT:
_____

DIAGNOSIS: _____

REASON FOR REFERRAL: _____

_____

_____

/Turn over

DESCRIBE CHILD/FAMILY NEEDS:

_____

_____

_____

DESCRIBE HOW YOU WILL COLLABORATE WITH THE EARLY CHILDHOOD INTERVENTION PROGRAM IN DEVELOPING AN INDIVIDUALIZED SERVICE PLAN (ISP) FOR THE CHILD AND FAMILY (IF THE PARENTS SO CHOOSE).

_____

_____

_____

_____

_____

_____

_____

I have ____ I have not ____ discussed my referral to the Prince Albert Early Childhood Intervention Program with the child's parent(s)/guardian(s).

_____ _____

SIGNATURE OF REFERRING AGENT DATE

_____

POSITION