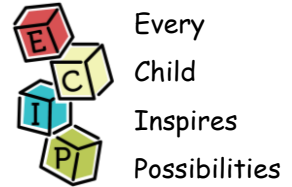


# Saskatoon Region

## Early Childhood Intervention Program Inc.

Suite 10 - 2302 Hanselman Avenue, Saskatoon, Saskatchewan S7L 5Z3

Ph: (306) 657-3247 Fax: (306) 249-3247 e-mail: arlene@saskatoon.ecip.ca



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### Referral For Early Childhood Home Based Intervention Services

Date: \_\_\_\_\_

Child's Name: \_\_\_\_\_  
(First) (Middle) (Last)

M/F: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age at referral: \_\_\_\_\_ months

Parents Full Names : \_\_\_\_\_  
Mother Father

Foster parents Yes \_\_\_\_\_ No \_\_\_\_\_ (Mark with X)

Languages spoken in the home: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone: #1. \_\_\_\_\_ #2: \_\_\_\_\_ #3: \_\_\_\_\_

Email: \_\_\_\_\_

Referring Agent: \_\_\_\_\_

Agency: \_\_\_\_\_

Address: \_\_\_\_\_ PC: \_\_\_\_\_

Telephone: \_\_\_\_\_ FAX: \_\_\_\_\_

Email: \_\_\_\_\_

Family gives consent to: (Check box)

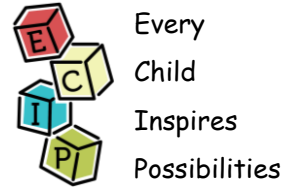
Share referral information with ECIP.

Share information about their child and family with the Ministry of Education and also the Saskatoon Region ECIP Admission and Transition Committee.

*Please fill out Page 2*

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Diagnosis: \_\_\_\_\_

Rate the child's needs: \_\_\_\_\_

*(rate needs 1 to 5)*

Rate the family's needs: \_\_\_\_\_

1. Mild
2. Mild to Moderate
3. Moderate
4. Moderate to Severe
5. Severe

Please identify your 3 main areas of concern:

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

Reason for referral and any additional information: