Saskatoon Region Early Childhood Intervention Program Inc.

Referral For Early Childhood Home Based Intervention Services

Today's Date: _____

Child's Name: _____
(First) (Middle) (Last)

Male: _____ Female: _____ Other: _____ Prefer not to say: _____

Date of Birth: _____

Primary Contact:

Name: _____

Address: _____

City: _____ PC: _____

Phone: #1. _____

Phone: #2: _____

Email: _____

Secondary Contact:

Name: _____

Address: _____

City: _____ PC: _____

Phone: #1. _____

Phone: #2: _____

Email: _____

Foster parents Yes _____ No _____ (*Mark with X*)

If yes, what is your length of time with child: _____

Languages spoken in the home: _____

Referring Person/Agent/Caregiver: _____

Agency: _____
(if applicable)
Address: _____ PC: _____

Telephone: _____ FAX: _____

Email: _____

Family gives consent to:

☐ Share referral information with Saskatoon Region ECIP.

Diagnosis: _____ or

☐ No confirmed 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 in the child's development:

1. _____

2. _____

3. _____

Reason for referral and any additional information:

Contact Information:
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