



**Early Childhood Intervention Program
Referral Form**

Name of Child: _____

Date of Birth: _____

Address: _____

Phone Number: _____ THIS#: _____

Medical Condition/Allergies/Medication: _____

Name of Parent/Guardian: _____

Phone Number: Daytime: _____ Evening: _____

Emergency Contact: _____ Phone _____

Name of Referring Individual: _____

Agency: _____

Date of Referral: _____

Reason for Referral: _____

Other areas of concern:

___ gross motor (e.g. sitting, crawling, walking, running) ___ behaviour ___ social

___ fine motor (e.g. drawing, picking up small objects) ___ overall development

___ language: ___ receptive ___ expressive ___ sensory ___ hearing

Is Parent or Guardian aware of referral? _____



Office use only

Name of Community Program: _____

Name of EI Worker: _____

Day/Time of Program: _____

Program Start Date: _____

Goals Setting Meeting: _____