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

REFERRAL FOR SERVICES

REFERRAL FOR (PLEASE CHECK ONE OF THE FOLLOWING):

☐ **EARLY CHILDHOOD INTERVENTION SERVICES** – home based visiting (all children ages 0-6)

☐ **CONNECTIONS** – service coordination with indigenous services (age 6-17)

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

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

SEX: MALE: ☐ FEMALE: ☐ NOT SPECIFIED: ☐ AGE AT REFERRAL:_____

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

TREATY # _____ BAND _____

PARENTS / FOSTER PARENTS / GUARDIAN: _____

RELATIONSHIP TO CHILD: _____

LANGUAGES SPOKEN:_____

PHYSICAL ADDRESS: _____POSTAL CODE: _____

MAILING ADDRESS (if different than above):_____

PHONE: HOME: _____ WORK: _____ CELL: _____

EMAIL ADDRESS:_____

REFERRING AGENT: _____

AGENCY: _____

ADDRESS: _____ POSTAL CODE: _____

TELEPHONE: _____FAX: _____

EMAIL ADDRESS:_____

LENGTH OF TIME ASSOCIATED WITH CHILD/FAMILY: _____

_____

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

DIAGNOSIS: _____

_____

_____

REASON FOR REFERRAL: _____

_____

_____

_____

_____

_____

PLEASE IDENTIFY YOUR 3 MAIN AREAS OF CONCERN:

1._____

2._____

3._____

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

☐ PAECIP can contact me for further information.

_____ _____
SIGNATURE OF REFERRING AGENT DATE

_____
POSITION