

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: _____

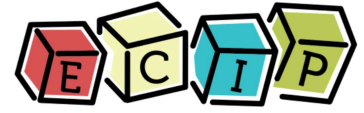
LENGTH OF TIME ASSOCIATED WITH CHILD/FAMILY: _____

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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