0-6 EARLY YEARS INTERVENTION REFERRAL FORM
LAICHWILTACH FAMILY LIFE SOCIETY

Early support. Strong beginnings. Bright futures.
Serving children from birth to 6 years old and their families.

PLEASE COMPLETE ALL SECTIONS. INCOMPLETE FORMS MAY DELAY SERVICES

Service Requested: ☐ AIDP ☐ AOT ☐ ASLS ☐ ASCD

1. CHILD INFORMATION

Name of Child: Date of Birth: (MMM-DD-YYYY):
Personal Health Number: Gender: ☐ Male ☐ Female
Indigenous Identity: ☐ First Nations: ☐ Metis ☐ Inuit
Home Address: Postal Code:

2. PARENT / GUARDIAN INFORMATION

Parent / Guardian Name: Relationship to Child:
Phone: Cell:
Email:
Preferred method of contact: ☐ Phone ☐ Email ☐ Text

Parent / Guardian Name: Relationship to Child:
Phone: Cell:
Email:
Preferred method of contact: ☐ Phone ☐ Email ☐ Text

3. REFERRAL SOURCE

Referral Date:
Referral Source: ☐ Parent/Guardian ☐ Physician ☐ Therapist ☐ Childcare /Preschool
☐ Public Health Nurse ☐ Social Worker ☐ Community Agency ☐Other
Name: Position/Title:
Agency/Organization:
Phone: Email:
Family Awareness & Consent (required for professional referrals)
Parent / Guardian aware of referral: ☐ Yes ☐ No
Parent / Guardian consent obtained: ☐ Yes ☐ No Date:

4. REASON FOR REFERRAL (Check all that apply)

☐ Speech & Language ☐ Gross Motor Skills ☐ Fine Motor Skills ☐ Feeding / Swallowing
☐ Sensory Processing ☐ Behaviour / Social Emotional ☐ Play Skills ☐ Cognitive Development
☐ Developmental Delay ☐ Autism Spectrum Concerns ☐ Prematurity ☐Medical Diagnosis
☐ Hearing Concerns ☐Vision Concerns ☐ Other:

5. CONCERNS & STRENGTHS OF CHILD

Please describe your concerns and strengths

6. MEDICAL & DEVELOPMENTAL HISTORY

Physician / Pediatrician Name: Phone:
Diagnosis / Medical Conditions:
Medications:
Allergies:
Hearing: ☐ No concerns ☐ Concerns ☐ Tested: Date:
Vision: ☐ No concerns ☐ Concerns ☐ Tested: Date:
Significant Medical History:

7. CONSENT TO REFER & EXCHANGE INFORMATION

I give permission for Laichwiltach Family Life Society to collect, use and share information about my child and family for the purpose of assessment, case planning, service coordination and evaluation. Information may be shared with relevant service providers involved in my child's care. I understand I can withdraw this consent at any time.

Parent / Guardian Name: (Please Print):

Signature: Date:

8. ATTACHMENTS (IF AVAILABLE)

☐Physician Report ☐Therapy Reports ☐Developmental Assessments ☐Hearing Results
☐ Vision Report ☐ Psychological Report ☐ School / Daycare Information ☐Other: