



**PRINCE ALBERT EARLY CHILDHOOD INTERVENTION PROGRAM, INC.**

#201 1008 1<sup>st</sup> Avenue West  
Prince Albert, SK S6V 4Y4  
Telephone: (306) 922-3247  
Fax: 763-5244 E-mail: [paecip@sasktel.net](mailto:paecip@sasktel.net)

CONFIDENTIAL: NOT TO BE COPIED OR REDISTRIBUTED  
FOR COPIES OR FURTHER INFORMATION, PLEASE CONTACT SOURCE OF ORIGIN.

**REFERRAL FOR EARLY CHILDHOOD INTERVENTION PROGRAM SERVICES**

DATE:

\_\_\_\_\_ (Day) (Month) (Year)

CHILD? NAME: \_\_\_\_\_

(First) (Middle) (Last)

SEX: Male: \_\_\_\_ Female: \_\_\_\_

BIRTH DATE:

\_\_\_\_\_ (Day) (Month) (Year)

S.H.S/TREATY # \_\_\_\_\_ BAND \_\_\_\_\_

AGE AT REFERRAL:

\_\_\_\_\_

PARENTS / FOSTER PARENTS / GUARDIAN: \_\_\_\_\_

RELATIONSHIP TO CHILD: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ POSTAL CODE: \_\_\_\_\_

PHONE: HOME: \_\_\_\_\_ WORK: \_\_\_\_\_ CELL: \_\_\_\_\_

REFERRING AGENT: \_\_\_\_\_

AGENCY: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ POSTAL CODE: \_\_\_\_\_

TELEPHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

\_\_\_\_\_

LENGTH OF TIME ASSOCIATED WITH CHILD/FAMILY: \_\_\_\_\_

FREQUENCY AND INTENSITY OF CONTACT:

\_\_\_\_\_

DIAGNOSIS: \_\_\_\_\_

REASON FOR REFERRAL: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ /Turn over

DESCRIBE CHILD/FAMILY NEEDS:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

DESCRIBE HOW YOU WILL COLLABORATE WITH THE EARLY CHILDHOOD INTERVENTION PROGRAM IN DEVELOPING AN INDIVIDUALIZED SERVICE PLAN (ISP) FOR THE CHILD AND FAMILY (IF THE PARENTS SO CHOOSE).

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_  
SIGNATURE OF REFERRING AGENT

\_\_\_\_\_  
DATE

\_\_\_\_\_  
POSITION