KOOTENAY FAMILY PLACE
EARLY INTERVENTION SERVICES
REFERRAL FORM

767 11TH Ave
Castlegar, BC, V1N 1J7
250-365-5616
1888-644-5616
Fax: 250-365-5792
www.kootenayfamilyplace.org

REFERRAL DATE: _____ PARENT IS AWARE OF REFERRAL: ☐

PLEASE CHECK OFF REQUESTED SERVICES	**Supported Child Development Program** (West Kootenay Boundary) ☐	**Infant Development Program** (Castlegar, Trail, Rossland, Nelson & areas & Slocan Valley to Nakusp) ☐
Physiotherapy (Castlegar and Trail) ☐	**Occupational Therapy** (Castlegar and Trail) ☐	**Speech Therapy** (Castlegar area & Nakusp area) ☐

CHILD/FAMILY INFORMATION:

CHILD: _____ **DOB:** _____ **GENDER:** _____

FOSTER CHILD: Yes No **ABORGINAL HERITAGE:** Yes No

PARENT/CAREGIVER: _____ **Phone**: _____

PARENT/CAREGIVER: _____ **Phone:** _____

Address: _____ **City:** _____ **Postal:** _____

House directions: _____ **Email:** _____

Safety Factors in home: _____

REFERRAL INFORMATION:

REFERRAL SOURCE: _____ **PHONE:** _____

For infants, only: Gestational Age: _____ APGARS: _____ Birth Weight: _____

REASON FOR REFERRAL (Please provide as much information as possible):

_____
_____
_____
_____
_____

OTHER SERVICE PROVIDERS (ex. Pediatrician, Physiotherapist, GP):

_____
_____

OFFICE USE ONLY:

I have read the information above, it is correct, and I agree to service. I have received/reviewed the KFP Handbooks.

Parent/Guardian Signature: _____ Date: _____

KFP Service Provider: _____ Date: _____

Acceptance Date: _____

ON DATABASE ☐