EAST KOOTENAY INFANT DEVELOPMENT PROGRAM
16 12th Avenue N., Cranbrook, B.C. V1C 3V7
(250) 426-2543 FAX 426-0543 1-877-999-2543
idp.cbk1@ccssebc.com or idp.cbk2@ccssebc.com

REFERRAL FORM

CHILD'S INFORMATION

First Name	Last Name	
Birthdate (Month/Day/Year)	Male/Female	Age at Referral

Personal Health Number	Birth Hospital	Birth Weight

Aboriginal/Cultural Background

☐ Aboriginal ☐ Other (explain) _____

☐ Metis _____

PARENT/GUARDIAN INFORMATION

Name	Relation to Child	Phone #

Street Address / Box number	Unit Number

City	Postal Code	Email Address

SIBLINGS

Name(s)	Date of Birth (month/day/year)	Age(s)

REASON FOR REFERRAL/DIAGNOSIS (if known)

Prematurity: Expected Due Date	Gestation Age

Describe any complications	

REFERRAL SOURCE

Name	Email Address

Address	Phone Number

OTHER REFERRALS / PROFESSIONAL CONTACTS

DR/ PEDIATRICIAN:

CONSENT FOR REFERRAL GIVEN BY: _____
(Parent /Guardian)

_____ or _____ _____
Signature Verbal Consent received by Date (month/day/year)

Date of referral received –	**Date Accepted into Caseload –**