# Richmond Infant Development Program Referral Form

ADDRESS:#170-7000 MINORU BLVD., RICHMOND BC, V6Y 3Z5 PHONE: 604-279-7058 FAX: 604-279-7048 EMAIL: idp@rscl.org

| DATE OF REFERRAL | REFERRAL SOURCE |
|---|---|
| ____ /____ /____<br>*mm dd yy* | _____<br>*Name* *Title/Agency* *Phone #* |

**CHILD & FAMILY INFORMATION**

Child's Name:

_____
*Last Name* *First Name*

D.O.B.(mm/dd/yy): ____ /____ /____ Gender: ☐ Male ☐ Female

Home Address:_____

Postal Code:_____ Buzzer#:_____

Parent/Caregiver:_____Relationship:_____

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Are there any cultural or religious customs of which we should be aware of?

Do you have any information that may indicate a potential risk to a home visitor?

**CONTACT**

Primary Phone Number:

Alternate Phone Number:

Email Address:

**LANGUAGE NEEDS**

Language(s) spoken in the home:

Interpreter needed? ☐ Yes ☐ No

**BIRTH INFORMATION**

Hospital:_____

Birth Weight:_____

Gestational Age: _____

Due Date: _____

*If attaching additional information and reports to this referral, please complete the following:*

Attachments?: ☐ Yes ☐ No

# of pages: _____

☐ **Parent(s) agree to referral**

**REASON FOR REFERRAL***(Check ALL that apply)*

**Developmental Delays/Concerns**
- ☐ Cognitive
- ☐ Language/Communication
- ☐ Gross Motor
- ☐ Fine Motor
- ☐ Social/Emotional
- ☐ Challenging Behaviours (describe):

**At Risk—Environmental**
- ☐ Foster child
- ☐ Other(please describe):

**At Risk—Medical**
- ☐ Prematurity
- ☐ Feeding Challenges
- ☐ Cardiac Complications
- ☐ Vision
- ☐ Hearing
- ☐ Seizures
- ☐ Neurological Abnormalities
- ☐ Metabolic Conditions
- ☐ Genetic Disorder
- ☐ Prenatal Substance Exposure
- ☐ Other:_____

**AGENCIES/PROFESSIONALS INVOLVED** (E.G. GP, PEDIATRICIAN, PUBLIC HEALTH NURSE, THERAPISTS, MCFD)

| Name/Title | Phone/Fax |
|---|---|
| 1. | |
| 2. | |
| 3. | |
| 4. | |