sources
EARLY CHILDHOOD DEVELOPMENT SERVICES

INFANT DEVELOPMENT PROGRAM
301A 8352-130 Street, Surrey, BC V3W 8J9
Tel: 604-590-7302 Fax: 604-590-7362

Intake Information Form

Please be thorough in providing information as this helps us to determine which stream of service provision will best meet the needs of this family. Please include completed developmental summaries (i.e. ASQ).

Date of Referral: _____ **Foster: Y N Aboriginal Y* N**

Family Information: ***If YES, please fax to AIDP at 604-595-1176**

_____ _____
Child's First Name **Last Name** **Date of Birth (month/day/year)**

_____ _____
Name of Mother or Foster Mother **Name of Father or Foster Father**

Address: _____

Contact Numbers: (Home): _____ (Cell): _____

Other Numbers/Email: _____

Are the parents aware of the referral? Y N

Interpreter Required: Y N Language used in the home: _____

Referral Information:

Birth Hospital: _____ Gender: M F Gestation (weeks): _____ Birth Weight: _____

Age at Referral: _____ (months)

Name of Referral Source: _____ Contact Number: _____

Reason for Referral: *(Please read all the categories to determine which is most applicable.)*

❑ **Prematurity**: Expected Due Date: _____ Describe any complications: _____

_____

❑ **Developmental Delays** (**Check all that apply):** ❑ communication ❑ gross motor ❑ fine motor
❑ cognitive (information processing/problem solving/general learning ❑ other (please specify below)

❑ **ISUM** (prenatal substance exposure)

❑ **Atypical Development**: ❑ genetic disorder ❑ metabolic disorder ❑ neurological disorder
❑ hearing ❑ vision ❑ seizures

Details: _____

❑ **Autism**: ❑ diagnosed ❑ symptoms

❑ **Child in Care of the Ministry of Children & Family Development**

Additional Information: (Referrals already completed/other professionals involved/more details re: condition.)

_____

_____

_____

_____

_____

For Office Use Only:		*Revised: July 2014*
Area:	Reason referred:	Client Number: