# Referral Form

**Date: _______________, 20_____**

**Child's Name: _________________________________________**

**Male: _____ Female: _____ Birth date: ______________________, _______**

**Age at Referral: ______ SHS: _________________Band & Treaty #_____________________**

**Parent(s)/Guardian(s): __________________________________________________________**

**Address: ___________________________________________________Postal Code: ________**

**Telephone: (Home) ________________________ (Work) ____________________________**

Diagnosis: _____________________________________________________________________

Reason for Referral: _____________________________________________________________

_______________________________________________________________________________

Describe child/family needs: ______________________________________________________

Family involved with KidsFirst__________ Child in care of Ministry of Social Services_____

Referring Agent: ______________________Agency_____________________________________

Address:______________________________________________Phone:______________________

Length of time associated with child/family:__________________________________________

Frequency and intensity of contact:_________________________________________________

Are you available to collaborate with Early Childhood Services in developing an Individualized Family Support Plan: _____________________________________________________________

**I have______I have not______discussed my referral to Meadow Lake Early Childhood Services with the childs parent(s)/guardian(s).**

**Signature of Referring Agent/Parent____________________ Position: _____________________**

Please send Referral to:
Box 2368, 201 4th Ave East, Meadow Lake, SK. S9X 1Z5
**Phone:** 306-236-4247 **Fax:** 306-236-1479 **E-Mail:** meadowlake.ecip@sasktel.net