

# EARLY CHILDHOOD INTERVENTION PROGRAM

REGINA REGION INC.

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Date: \_\_\_\_\_

Referral for (please check one of the following):

- Early Childhood Intervention Services** – Home based visiting (0-6 years of age)
- Specialized Support Program** - Service coordination with Indigenous Services Canada (6-17 years of age)

Child/Youth's Name: \_\_\_\_\_ Gender: Male  Female  Not Specified

Birth Date: \_\_\_\_\_ Age at Referral: \_\_\_\_\_

S.H.S. #: \_\_\_\_\_ Treaty #: \_\_\_\_\_ Band: \_\_\_\_\_

Physical Address: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Mailing Address (if different than above): \_\_\_\_\_

Languages spoken at home: \_\_\_\_\_

Parent/Caregiver 1: \_\_\_\_\_  
 Relationship to child/youth: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Postal Code: \_\_\_\_\_  
 Telephone: \_\_\_\_\_  
 Email: \_\_\_\_\_  
 Preferred Contact:  Phone  Text  Email

Parent/Caregiver 2: \_\_\_\_\_  
 Relationship to child/youth: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Postal Code: \_\_\_\_\_  
 Telephone: \_\_\_\_\_  
 Email: \_\_\_\_\_  
 Preferred Contact:  Phone  Text  Email

**Reason for Referral:**  
 (please check all which apply and give brief description):

- Diagnosis
- Experiencing Delay
- At Risk for Delay

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Please identify the primary areas for ECIP support:**  
 (please check all which apply and give brief description):

- Child Development
- Service Coordination
- Community Connections
- Family Support

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

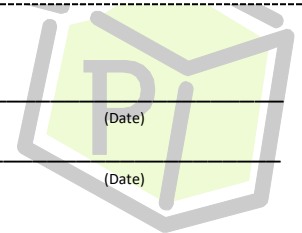
**To be completed if referred by an organization:**

Referral Name: \_\_\_\_\_ Position: \_\_\_\_\_  
 Organization: \_\_\_\_\_  
 Address: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
 Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Email: \_\_\_\_\_

Has this referral been discussed with the parent/caregiver?      YES      NO

Signature of Parent/Caregiver: \_\_\_\_\_

**OR** Referring Individual/Organization: \_\_\_\_\_



(Date)

(Date)