EARLY CHILDHOOD
INTERVENTION PROGRAM
REGINA REGION INC.

Suite 305, 1102 - 8th Avenue, Regina, Saskatchewan, Canada S4R 1C9
Tel: 306.347.5020 Fax: 306.347.5030 Email: ecip.rr@ecip.ca Web: www.regina.ecip.ca

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: _____ Sex: Male ☐ Female ☐ Not Specified ☐
(first) (middle) (last)
Birth Date: _____ Age at Referral: _____
(MM/DD/YEAR) (year, months)
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: _____ _____
(Date)
OR Referring Individual/Organization: _____ _____
(Date)