Port Alberni Early Intervention Team (EIT)
4325 Neill Street, Port Alberni, B.C. V9Y 1E5
Fax: 250-723-7349

NEW REFERRAL

Referral Date: _____ EIT Mtg Date: _____
DA / MO / YR **DA / MO / YR**

Child's Name: _____ Sex: _____ DOB: _____
LAST, First **DA / MO / YR**

Parent(**s**) / Foster Parent(**s**): _____

Mailing Address: _____

Postal Code _____ Telephone: (Home) _____ (Work) _____

Email Address: _____

Legal Guardian(**s**) _____ ☐ USMA ☐ MCFD

Family Doctor: _____ Pediatrician: _____

Service(s) Requested:

- ☐ Infant Development Program
- ☐ Physiotherapy
- ☐ Supported Child Development Program
- ☐ Speech Therapy
- ☐ Occupational Therapy
- ☐ Early Years Outreach Program (Nuu-chah-nulth)

Reason for Requesting Service:

_____

_____

_____

What has been done so far to address these concerns? _____

_____

_____

Has parent consented to this referral being made & discussed at the EIT Intake meeting? Yes ☐ No ☐

Does the Family/Guardian consider this child to be aboriginal? (Please check one)
Yes ☐ On Reserve ☐ Off Reserve ☐ No ☐ Declined ☐

Thank you for taking the time to answer this question. Contracts with the Ministry of Children & Family Development (MCFD) require us to ask for this information to help MCFD make future decisions about program funding and service delivery. Choosing to share this information remains the right of the family/guardian and is at their sole discretion.

Referred by: _____ Position: _____

Address: _____

Telephone: _____ Information Taken By: _____