

Early Intervention Team (EIT)

Port Alberni, Tofino, Ucluelet, Bamfield, Ditidaht, & West Coast Communities
4325 Neill Street, Port Alberni, B.C. V9Y 1E5
Telephone: 250-723-1117
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NEW REFERRAL

Referral Date: _____
DA / MO / YR

EIT Mtg Date: _____
DA / MO / YR

Child's Name: _____ Gender _____
LAST, First

DOB: _____
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:

- | | |
|---|--|
| <input type="checkbox"/> Infant Development Program | <input type="checkbox"/> Speech Therapy |
| <input type="checkbox"/> Physiotherapy | <input type="checkbox"/> Occupational Therapy |
| <input type="checkbox"/> Supported Child Development Program: | <input type="checkbox"/> Early Years Outreach Program
(Indigenous Services) |
| <input type="checkbox"/> Daycare | <input type="checkbox"/> FASD Key Worker (0-19 yrs) |
| <input type="checkbox"/> Preschool | |
| <input type="checkbox"/> OSC | |

Reason for Requesting Service: Please attach any supporting documents

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

<p>Does the Family/Guardian consider this child to be Indigenous? (Please check one)</p> <p>Yes <input type="checkbox"/> On Reserve <input type="checkbox"/> Off Reserve <input type="checkbox"/> No <input type="checkbox"/> Declined <input type="checkbox"/></p> <p><i>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.</i></p>

Referred by: _____ Position: _____

Address: _____

Telephone: _____ Information Taken By: _____