NWT Disabilities Council

ECIP Early Childhood Intervention Program

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Early Childhood Intervention Program
Referral Form

Name of Child: _____ Date of Birth: _____

Address: _____

Name of Parent/ Legal Guardian: _____

Phone Number: Home:_____ Cell: _____ Work: _____

Alternate Contact Number: _____Email: _____

Name of Physician/Health Professional: _____

Suspected: _____ by: _____

Name of Referring Individual: _____

Diagnosis completed?_____

Is parent/guardian aware of referral? Yes_____ No_____

Agency: _____ Position: _____

Date of Referral: _____ Reason for Referral: _____

Areas of concern:

☐ Gross motor (e.g. sitting, crawling, walking, running)

☐ Fine motor (e.g. drawing, picking up small objects)

☐ Language/Communication: _____receptive _____expressive

☐ Hearing

☐ Visual

☐ Global Delay, specify:_____

☐ Anxiety/acting out

☐ Social

☐ Sensory

Others, identify: _____

The parent/guardian will be contacted by the children's services manager to complete a formal intake upon receipt of the referral form.