NWT Disabilities Council

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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: _____

Diagnosis completed: _____

Name of Physician/Health Professional: _____

Suspected: _____ by: _____

Name of Referring Individual: _____

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

____ Global Delay

___ Anxiety/acting out

____ Social

____ Sensory

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