INFANT DEVELOPMENT PROGRAM

*Sponsored by **AiMHi** - Prince George Association for Community Living*
Funded by Ministry for Children & Family Development
950 Kerry St. Prince George, BC V2M 5A3

Phone: 250-564-6408
Fax: 250-564-6801
Email: idp@aimhi.ca

REFERRAL / APPLICATION FORM

FAMILY INFORMATION		**IDP Central Registry #**	
Parents/Caregivers:		**Date of Referral:**	
Address:		Child's Name:	
City:	Postal Code:	**DOB** (day/month/year):	
Telephone(s):		Age at Referral:	Sex:
Email(s):		Does the family require an interpreter?	Language:
Sibling(s) Names & Age(s):			
Are there any cultural, ethnic, religious or spiritual considerations the family would like us to be aware of?			

BIRTH & HEALTH INFORMATION	
Hospital:	
Birth Weight:	Gestational Age:
Age at which problem detected by parents/caregivers/other professional?	

REFERRAL INFORMATION	
Reason for Referral:	
Referral Source *(Name & Position)*:	
Phone:	*The IDP will send a confirmation of this referral via your provided fax or email address.*
Fax/Email:	
By initialing here you agree that the parent/caregiver is informed about the IDP and agrees to the referral:	
Other Services Involved *(Service or Agency, Person, Contact Information)*:	
Prior Assessments *(Type, Provider, Date)*:	
Doctor(s):	
Medical Concerns/Medications:	

SIGNATURES	
Parent/Caregiver Signature(s)	
IDP Consultant Signature	