AiMHi
PRINCE GEORGE ASSOCIATION FOR COMMUNITY LIVING

INFANT DEVELOPMENT PROGRAM

Funded by Ministry for Children & Family Development
950 Kerry St. Prince George, BC V2M 5A3

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Fax: 855-237-3100
Email: idp@aimhi.ca

REFERRAL / APPLICATION FORM

FAMILY INFORMATION		**IDP Central Registry #**
Parents/Caregivers:	**Date of Referral:**	
Address:	Child's Name:	
Postal Code:	**DOB** (day/month/year):	
Telephone(s):	Age at Referral:	Sex at birth:
Email(s):	Does the family require an interpreter? ☐Y ☐N	Language:
Sibling(s) Names & Age(s):		
Are there any cultural, ethnic, gender, 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:	*Referral confirmation will be sent via fax*
Fax:	
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):	Paediatrician:
Medical Concerns/Medications:	

Parent/Caregiver Signature(s)	
IDP Consultant Signature	