Burnaby Infant Development Program

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Burnaby Association for Community Inclusion

Referral Information Form

Date of Referral:_____ **Date Registered:**_____ **Registry Number:**_____

Child's Name:_____ **Date of Birth (month/day/year):**_____

Mother's Name:_____ **Father's Name:**_____

Address:_____ **Postal Code:**_____

Contact Numbers: (Home)_____ **(Cell)**_____

Other Numbers: _____ **(Email)** _____

Relevant Information:

Birth Hospital: _____ **Gender:**_____ **Gestation(weeks):**_____ **Birth Weight(grams):** _____

Age at Referral:_____ **(months)** **Siblings:**_____ **Care Card #:** _____

Source of Referral: _____

Reason for Referral: _____

Diagnosis and Additional Information: _____

_____

Physician(s): **(Address/Phone Numbers)**

Pediatrician: _____

Family Doctor: _____

Other Doctors: _____

Other Agencies/Professionals Involved: _____

_____

_____

Are the parents aware of this referral? ☐ **Yes** ☐ **No**

Language(s) used in the home: _____ **Interpreter Required?** ☐ **Yes** ☐ **No**

Are there any Cultural or religious observances we should be aware of? _____

Do you have any information that may indicate a potential risk to a home visitor? (eg. pets/smoking/ construction/violence in the home/restraining order etc.) ☐ **Yes** ☐ **No** ☐ **Not enough information**

If yes, please describe:_____

_____

_____
IDP Consultant