VANCOUVER INFANT DEVELOPMENT PROGRAM
3455 Kaslo Street, Vancouver, BC V5M 3H4 Tel: (604) 435-8166 Fax: (604)709-4553 Email: vancouveridp@develop.bc.ca

REFERRAL FORM

Referral Date: _____ (month) _____ (day) _____ (year) Referred by: _____ Agency (If applicable): _____

Child's First Name: _____ Last Name: _____ REF #: _____

Child's Birthdate: _____ (month) _____ (day) _____ (year) Expected due date: _____ (month) _____ (day) _____ (year) Gender: ☐ female ☐ male

Child's PHN#: _____ Birth Hospital: _____

Gestational Age: _____ Birth Weight: _____ Age at which problem was detected: _____

Age at Referral: _____ Primary Language: _____ Interpreter Required: _____

Reason for Referral:

☐ Prematurity: Describe any complications: _____

☐ Developmental Delays (Check all that apply): ☐ communication ☐ gross motor ☐ fine motor
☐ cognitive (information processing/problem solving/general learning ☐ behaviour ☐ other (please specify below)

☐ Prenatal Substance Exposure: ☐ identified ☐ suspected

☐ Identified Conditions: ☐ genetic disorder ☐ metabolic disorder ☐ neurological disorder
☐ hearing ☐ vision ☐ seizures ☐ cardiovascular ☐ other: _____

☐ Autism: ☐ diagnosed ☐ suspected

Additional Comments: _____

This child is also referred to: ☐ VCH SLP ☐ PHN ☐ BCCFA ☐ SCD ☐ other: _____

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Parents/Guardians Full Names: _____ ; _____

Address: _____

City, Prov: _____ Postal Code: _____

Home Phone: _____ Cell Phone: _____ Cell Phone: _____

Email: _____ Alternate Email: _____

Any Siblings (Names/Ages): _____ Child lives with: _____

Contact for appointments (if other than parent): _____ Phone: _____

****

Professional Contacts:

Pediatrician: _____ Phone: _____

Physician: _____ Phone: _____

PHN and UNIT: _____ Phone: _____

Social Worker: _____ Phone: _____

Other Professional: _____ Phone: _____

Parents agree to referral: ☐ Yes ☐ No Parent signature: _____

For office use only: Reason for Referral: _____ IDP Consultant Initial: _____
Referral Completed by: _____ Date: _____