Boundary Infant Development Program (IDP)

Boundary Infant Development Program
Box 2498, 1200 Central Ave., Glanville Centre
Grand Forks, BC V0H 1H0
Phone: 250-442-2267 ext 40234
Email: info@bfiss.org

REFERRAL FORM

FAMILY INFORMATION

Name of Infant: _____
D.O.B._____
Age at Referral: _____Gender: _____
Aboriginal Ancestry □ Yes _____
Mother's Name: _____
Father's Name: _____
Address: _____
_____
Telephone (H)_____ (W)_____

Siblings

Name: _____Age: ____
Name: _____Age: ____
Name: _____Age: ____

REFERRAL DATA

Date of Referral _____
Referral Source: _____
Reason for Referral _____

BIRTH INFORMATION

Hospital: _____
Birth Weight: _____
Gestational Age: _____

Agencies Involved

Foster Child: Yes _____ No_____
Name of Agency Name of Worker
_____
_____

Diagnosis / Additional Information

_____
_____
_____
_____

Assessments	Type	By Whom	Date

_____
_____

Physicians **Medical Concerns**

_____
_____

Does the family require an interpreter? Yes: ___ No: ___ Language: _____
Are there any cultural or religious observances of which we should be aware?
_____
Do you have any information that may indicate a potential risk to a home visitor?
_____
Additional Comments: _____
_____
_____

Parent is informed about the IDP and wishes to participate.
Parent has been given the Parent Information Package. This consent is reviewed annually.

IDP Consultant Signature_____

Parent Signature _____