Circle of Indigenous Nations Society
1801 Connors Road
Castlegar, BC
V1N 3N9

WEST KOOTENAY BOUNDARY
ABORIGINAL INFANT DEVELOPMENT PROGRAM/ABORIGINAL SUPPORTED CHILD DEVELOPMENT

REFERRAL FORM

FAMILY INFORMATION
Name of Child: ______________________________
D.O.B.______________________________________
Age at Referral: ____________Gender: ________
Aboriginal Ancestry 💰 Yes ________________
Mother's Name: ______________________________
Father's Name: ______________________________
Address: ___________________________________
____
Telephone (H)____________ (W)____________

REFERRAL DATA
Date of Referral ___________________________
Referral Source: ___________________________
Reason for Referral _________________________

BIRTH INFORMATION
Hospital: __________________________________
Birth Weight: ______________________________
Gestational Age: ___________________________

Diagnosis / Additional Information/ Reason for Referral

____
____

Physicians **Medical Concerns**

____
____

Are there any cultural or religious observances of which we should be aware?

____

Additional Comments: ____
____

Parent is informed about the AIDP/ASCD and wishes to participate. (please circle program referred too)

AIDP/ASCD Consultant Signature____

Parent Signature & Consent of service ____

Contact and/or send referrals to:

West Kootenay AIDP & ASCD
Crystal Laren
Phone: 250-304-8926
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Boundary ASCD
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