



Yellowhead Community Services
Referral Form
Infant Development Program

FAMILY INFORMATION

Child: _____
 DOB (D/M/Y): ___/___/___
 Name(s) of Parents/Legal Guardians: _____

 Address: _____

 Mailing Address: _____

 Postal Code: _____
 Telephone: (H) _____ (W) _____

Siblings' Names: D.O.B. (D/M/Y)
 _____ _____
 _____ _____
 _____ _____
 _____ _____

Foster Parents Info: (If Applicable)

Social Worker: _____

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: _____

REFERRAL DATA:

Date of Referral (D/M/Y): ___/___/___
 Referral Source: _____
 Reasons for Referral: _____

 Diagnosis/Additional Info: _____

 Age at referral: _____
 Gender: Male / Female (Please circle)
 Personal Health #: _____
Parents Aware of Referral: Yes / No (Please circle)

BIRTH INFORMATION

Hospital: _____
 Gestational Age: _____
 Birth Weight (lbs) _____ Grams _____
 Physician(s): _____

 Medications: _____

AGENCIES INVOLVED:

Agency	Professional
_____	_____
_____	_____
_____	_____

Continued on reverse.....

REFERRAL FORM (cont.)

PRIMARY CRITERIA FOR ELIGIBILITY

Please tick if applicable:

- Infant referred is aged birth to three years
- Infant delayed or potentially delayed in one or more skill area
For example: gross motor, fine motor, adaptive speech/language
- Diagnosis. If so, list _____
- Socioeconomic status of family which may impact child development
- Intuitive feeling that something is not right
- Family agrees to participate
- Geographic location of family's home: McClure, Louis Creek, Barriere, Little Fort, Clearwater, Birch Island, Vavenby, Avola, Blue River
- Comments: _____

OTHER RISK FACTORS

The following infants are at highest risk for developmental delays and should be referred if present:

- Prematurity <29 weeks (High incidence of long term disabilities)
- Very low birth weight (VLBW) <1500 gm with complications
- Periventricular Leukomalacia (High incidence of Cerebral Palsy)
- Intraventricular Hemorrhage (IVH) Grade 3-4 Bleed (High incidence of CP)
- Congenital Anomaly
- Genetic Conditions
- Neonatal drug/alcohol exposure
- Extracorporeal membrane Oxygenation (ECMO) - 60% hearing impairment
- Retinopathy of Prematurity (ROP) Visual difficulties
- Bronchopulmonary dysplasia (BPD) / Chronic lung disease. Ventilation >7days
- Congenital infection
- Birth asphyxia (moderate – severe)
- Apgars less than 7 at 5 minutes
- Seizures
- Cardiac Anomaly
- Prolonged Hypoglycemia that doesn't respond to treatment
- Increased Bilirubin level
- Unusual muscle tone, asymmetry
- "Difficult Baby" (long standing problems with sleeping, feeding, crying, eating)
- Failure to thrive (FTT)
- Feeding difficulties
- NEC (Necrotizing Enterocolitis)
- Multiple Births
- Parental Health Issues (i.e. mental health concerns, chronic medical condition)
- History of abuse within the family
- Multiple foster care placements

CLEARWATER

612 Park Drive, Clearwater BC V0E 1N1
Telephone: 250-674-2600 Facsimile: 250-674-2676

BARRIERE

4936 Barriere Town Road, Barriere BC V0E 1E0
Telephone: 250-672-9773 Facsimile: 250-672-9709