



Children North

“Building Stronger Families”

PO Box 925

La Ronge, SK S0J 1L0

Ph: 306-425-6600

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**Early Childhood Intervention Program, Cognitive Disability Strategy, Family Support Program
Father Engagement Program, Specialized Support Program, Mentorship and Respite Care
Speech Language Program, Developmental Outreach Clinic**

REFERRAL FOR: (Please check all that apply)

Early Childhood Intervention: _____
Specialized Support Program: _____
Family Support Program: _____
Cognitive Disability Strategy _____

Pediatric Psychologist: _____
Pediatric OT: _____
SLP assessment only _____
Pediatric PT: _____

TODAY'S DATE: _____
(Day) (Month) (Year)

Should be seen at La Ronge Development Outreach Clinic? Yes _____ No _____

CHILD'S NAME: _____

GENDER: Male _____ Female _____ S.H.S. # _____

BIRTHDATE: _____ AGE AT REFERRAL: _____
(Day) (Month) (Year)

BAND: _____ TREATY #: _____

PARENTS/FOSTER PARENTS/GUARDIAN: _____

***ADDRESS: Civic/Street Address _____

Box # _____ Town _____ Postal Code _____

TELEPHONE: Home: _____ Work: _____ Cell: _____

Email Address: _____

REFERRING AGENT: _____

Is referring agent a doctor? Yes _____ No _____ If so, Doctor's Signature: _____

Diagnosis: _____

Reason for Referral (please be specific including any therapies that they may require):

PLEASE FILL OUT COMPLETELY. Do not leave blank spaces as this information is imperative to enroll child for services.