

The ITDP provides early intervention services and supports for families of infants and young children who have a developmental delay or who are at risk for delayed development.

Date of Referral:		Parent Consents to Referral (required): Yes <input type="radio"/> No <input type="radio"/>	
Child's Name:			
Date of Birth:	E.D.C.	Male <input type="radio"/> Female <input type="radio"/>	
Address:		Postal Code:	
Parent/Caregiver #1 Name:		Phone:	
Parent/Caregiver #2 Name:		Phone:	
Other household members (name, age, relationship):			
Family Physician:		Pediatrician:	
Other Services:			

Reason for Referral (check all that apply):	
<input type="radio"/> Prematurity: # weeks gestation:	<input type="radio"/> Delayed development
<input type="radio"/> Speech and Language Concerns	<input type="radio"/> Positional Preference/Plagiocephaly
<input type="radio"/> Diagnosis:	<input type="radio"/> Sibling with Autism Spectrum Disorder
<input type="radio"/> Feeding Concerns	<input type="radio"/> Other:

Additional Information:

Safety Issues:
Are there identified risks to safety, if visiting this family in their home?
<input type="radio"/> No <input type="radio"/> Yes, if yes please explain:

Interpretation:
Are interpretation supports required?
<input type="radio"/> No <input type="radio"/> Yes, if yes please indicate preferred language:

Referred by:	
Name:	Phone:
Agency:	

Please fax or mail this form to:
ITDP Peterborough Public Health - 185 King Street, Peterborough, ON K9J 2R8
Telephone: 705-743-1000 Fax: 705-741-4261

*The information on this referral form is collected under the authority of the Health Protection and Promotion Act applicable privacy legislation. Information will be used for delivery of public health programs and services. Any questions about the collection of this information should be directed to: Privacy Officer, Peterborough Public Health.*