Peterborough Public Health

Infant and Child Development Program (ICDP)

The ICDP 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 ☐ No☐
Child's Name:		
Date of Birth:	E.D.D.	☐Male ☐Female
Address:		Postal Code:
Parent/Caregiver #1 Name:		Phone:
Parent/Caregiver #2 Name:		Phone:
Email:		
Other household members (name, age, relationship):		
Family Physician:	Pediatrician:	
Other Services:		

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

Additional Information (gender identity/expression, language, culture, other):

Safety Issues:
Are there identified risks to safety, if visiting this family in their home?
☐No ☐Yes, if yes please explain:

Interpretation:
Are interpretation supports required?
☐No ☐Yes, if yes please indicate preferred language:

Referred by:	
Name:	Phone:
Agency:	

Please fax or mail this form to:
ICDP 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.

Revised: 06-26-2023