Infant & Child Development Program

Referral Form

433 McIntyre Street West, North Bay, ON P1B 2Z3
Tel: (705) 472-0910 Fax: (705) 667-0280

Children's Aid Society
La Société d'aide à l'enfance
NIPISSING & PARRY SOUND

Name:					**Gender:** ☐ **Male** ☐ **Female**
Date of Birth:	**Month**	**Day**	**Year**	**Age:**	**Gestation:**
Birth Weight:				**Apgar:**	
Mother:				**Date of Birth:** Month / Day / Yr.	
Address:					
Cell Number:				☐ **Tel #** ☐ **Alternate:**	
Father:				**Date of Birth:** Month / Day / Yr.	
Address:					
Cell Number:				☐ **Home** ☐ **Alternate:**	
Referring Agency:					
Referral Date:				**Person Referring:**	
Family Doctor:				**Pediatrician:**	
Reason for Referral:					
Current Custody or Guardianship Arrangement and contact info: (ie: shared custody, biological parents care, customary care, foster care, kinship service/care, etc.)					

Please indicate below any community services that ICDP has your consent to contact for service management purposes. You may withdraw your consent at any time by notifying your assigned ICDP worker.

☐ **Licensed Day Care Provider** Name:	☐ **Children's Aid Society** Case Worker Name:	☐ **CAPC/CPNP** Case Worker Name:
☐ **Healthy Babies/Health Children** Case Worker Name:	☐ **HANDSTheFamilyHelpNetwork** Case Worker Name:	☐ **One Kids Place** Therapist:
☐ **Other** (please list agency and assigned case worker):		

LEGAL GUARDIAN MUST CONSENT TO THIS REFERRAL:

****Has this Program been discussed with the legal Guardian(s) and do they support this referral?** ☐ **Yes** ☐ **No**

****Legal Guardian(s) consent to the exchange of information between Infant and Child Development Program and the Referring Agency/Person** ☐ **Yes** ☐ **No**

****What type of Consent has been obtained by the Guardian (s) to complete this Referral?** ☐ **Verbal** **or** ☐ **Signed Consent?**

Guardian Signature: _____ **Date:**

***note: Signature is not required for verbal consent alone.**

As the guardian listed on this form I hereby consent to share personal information with the referring agency listed herein, I further provide consent for my personal information, and that of the above named child, to be used by the Infant and Child Development Program for the purposes of research and evaluation so long as my information is non-identifiable and the research and evaluation services comply with the Tri-Council ethical requirements. I understand I may revoke this consent at any time by providing a request in writing to the supervisor of ICDP.

** indicates mandatory fields

Revised: Oct 2026

PLEASE FAX TO: 705 -667 -0280 or email
earlyinterventionservices**referrals**@parnipcas.org