Circle of Indigenous Nations Society
1005 2nd Street
Castlegar B.C. V1N 1Y4

WEST KOOTENAY BOUNDARY
ABORIGINAL INFANT DEVELOPMENT PROGRAM

REFERRAL FORM

FAMILY INFORMATION

Name of Child: _____
D.O.B._____
Age at Referral: _____Gender: _____
Aboriginal Ancestry □ Yes _____
Mother's Name: _____
Father's Name: _____
Address: _____
_____
Telephone (H)_____ (W)_____

REFERRAL DATA

Date of Referral _____
Referral Source: _____
Reason for Referral _____

BIRTH INFORMATION

Hospital: _____
Birth Weight: _____
Gestational Age: _____

Diagnosis / Additional Information

_____
_____

Physicians **Medical Concerns**

_____
_____

Does the family require an interpreter? Yes: ___ No: ___ Language: _____

Are there any cultural or religious observances of which we should be aware?

_____

Additional Comments: _____
_____

Parent is informed about the AIDP and wishes to participate.

AIDP Consultant Signature_____

Parent Signature _____

Contact and/or send referrals to:

West Kootenay AIDP
Crystal Laren
Phone: 250-304-8920
Email: crystal.coinations@gmail.com

Grand Forks & Boundary AIDP
Laranna Androsoff
Phone: 250-443-4387
Email: laranna.coinations@gmail.com