

SIMCOE COUNTY EARLY INTERVENTION SERVICES  
Individual Family Service Plan - Request For Service

Services Requested: 1.  See ERIK 2. \_\_\_\_\_ 3. \_\_\_\_\_

Who recommended this service? \_\_\_\_\_ Date: \_\_\_\_\_

Child's Name: \_\_\_\_\_ M  F

Date of Birth: \_\_\_\_\_

mm/dd/year

Health Card #: \_\_\_\_\_ Expiry Date: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Mailing Address (if different from above) \_\_\_\_\_

Parent's Name(s):

Parent 1: \_\_\_\_\_ Parent 2: \_\_\_\_\_

Address:  Same as Child Address:  Same as Child

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Home Phone #: \_\_\_\_\_ Home Phone #: \_\_\_\_\_

Work #: \_\_\_\_\_ Work #: \_\_\_\_\_

Cell #: \_\_\_\_\_ Cell #: \_\_\_\_\_

E-mail address: \_\_\_\_\_ E-mail address: \_\_\_\_\_

Custodial Parent(s)/Guardian(s): \_\_\_\_\_

Custody Arrangement (please specify): \_\_\_\_\_

Language(s) Spoken to Child: \_\_\_\_\_

Is there anything about your cultural/religious background you would like us to know? \_\_\_\_\_

Does your child have a confirmed diagnosis or disorder?  Yes  No

If yes, please explain:

**SIMCOE COUNTY EARLY INTERVENTION SERVICES**  
**Individual Family Service Plan - Request For Service Continued**

What specific concerns do you have?

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Other Services Involved/Already Requested: Please specify. Please include private services.

Family Doctor	_____
Paediatrician	_____
Speech-Language Pathologist	_____
Occupational Therapist	_____
Physiotherapist	_____
Neonatal Follow-up Clinic	_____
Infant Development Worker	_____
Early Intervention Worker/Resource Teacher	_____
Daycare/Nursery School/Childcare Program	_____
Hospital for Sick Children	_____
Healthy Babies Health Children	_____
Children's Aid Society	_____
Blind Low Vision	_____
Infant Hearing Program	_____
Family Support/Resource Worker	_____

Additional Professionals Involved (please specify):

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Verbal consent to the above information and referrals provided by \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_