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

Services Requested: 1. ☐ See ERIK 2. ______________ 3. ______________

Who recommended this service? ______________ Date: ______________
mm/dd/year

Child's Name: ______________ M ☐ F ☐ Date of Birth: ______________
mm/dd/year

Health Card #: ______________ Expiry Date: ______________
mm/dd/year

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? If yes, please explain: ☐ Yes ☒ No

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What specific concerns do you have?

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

Family Doctor	
Pediatrician	
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):

____

____

____

Verbal consent to the above information and referrals provided by: ______________________

Signature: ______________________ Date: ______________________