KidsFirst

Referral Form

Please type or print so that information is easily read
Fax referral to (306) 766-6325 or email
SHAKidsFirstRegina@saskhealthauthority.ca

Date _____ ☐ **Prenatal** ☐ **Postnatal** **Due Date:** _____

☐ **Interpreter required: Yes/No** **Language spoken:** _____

Have the parents received KidsFirst support before? ☐ **Yes** ☐ **No** **If yes, what city?** _____

Primary caregiver's name: _____ **Partner's name:** _____

Primary caregiver's HSN# _____ **Primary caregiver's DOB:** _____

Address: _____ **Postal code** _____ **Phone #** _____

How many children total? _____ **First time parent(s)?** ☐ **Yes** ☐ **No**

Please list children living in the home with Date of Birth: _____

List children living outside the home and their care arrangement. _____

Safety Concerns: ☐ **Dogs** ☐ **Mice** ☐ **Bedbugs** ☐ **Cockroaches** ☐ **Domestic violence**

Do you have any developmental/behavioural concerns regarding the child(ren)? _____

Any additional helpful information, including other agencies the family is involved with. _____

If accepted to KidsFirst, what do you hope our program can do for you/ your family? _____

Informed Consent: Informed consent has been given for the release of this information and for a referral to KidsFirst to determine if home visiting services would be helpful.

Name of Referral Source _____ Referral Source Signature _____

Agency Name _____ Agency Phone # _____

Caregiver Signature _____ or Verbal Consent Received _____

Revised: January 2022