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# Haida Gwaii Early Intervention Team Referral Form

<b>Childs Name:</b>	<b>MM/DD/YYYY</b>	<input type="checkbox"/> M	<input type="checkbox"/> F
Parent(s) Names:	Home Phone:		
Mailing Address	Work Phone:		
Physical Address:	Cell Phone:		
Postal Code:	Does this family identify as aboriginal:		<input type="checkbox"/> Y <input type="checkbox"/> N
Primary Language of Family: English <input type="checkbox"/> French <input type="checkbox"/> Other <input style="width: 150px;" type="text"/>			
<b>Reason for Referral:</b>			
Are parents aware of this referral? YES _____ If no why not? _____			
Referring name and title: _____			
Phone: _____			
Referring Source Signature: _____ Date: _____			

