KIDSFIRST REGINA REFERRAL FORM **Date of Referral: _____**

In order to become a KidsFirst Family it will require a weekly home visit, visits are usually M-F between 9-5 and your child MUST be home for the visits, is this something that you can commit too?

If No, then please understand that KidsFirst is not likely the program for you.

By providing this information, you consent to KidsFirst Regina contacting you or the referring agency to follow-up on this referral. If electronic communication is preferred, please indicate below your email and/or text only contact info:

Primary Caregiver: _____DOB: _____

HSN: _____ Partners Name: _____

Address: _____ Postal Code: _____

Phone Number: _____ Text only? _____ (check for yes)

Prenatal Family: _____ Due Date: _____

First time parent: _____ YES, _____ NO

Have you been on KFR Program Before? ____ YES, ___ NO

If yes, what agency were you with? _____

Is an interpreter required to assist, if so, what language? _____

Please list number of children currently living in the home (Please add names and birthdate):

_____

_____

_____

Are there any children under 18 living outside the home? Please explain their current care arrangements:

_____

_____

_____

What areas of family support would be best to support your needs as a parent? (The information gathered below will help us understand if KidsFirst is the best fit for you and support your goals as a family).

_____Child Development/Milestones

____ Child Behavior

____Pregnancy support/information

____ Growing a safe, secure family

____General Parenting Info

____ Parenting in Canada

____ Things to do in Regina with my family

____ Getting ready for school

Other (please explain): _____

_____

Any Safety issues that we should be aware of if we are coming to your home/apt building: (pests, dogs, weapon concerns, active gang involvement, legal proceedings, etc.)

_____

_____

_____

Are you or anyone in your home working with any other service providers such as, but not limited to: ECIP, Triple P, Wascana Children's Program, Fox Valley, Healthiest Babies Possible or Babies Best Start? Please indicate below:

_____

_____

_____

Name of Referral source: Self Phone

Referral Signature: _____

Referral Contact Number: _____

Verbal Consent received: _____

Parent/Caregiver Signature: _____

Please type or print – Fax completed form to (306) 766-6325 or email SHAKidsFirstRegina@saskhealthauthority.ca