Centre intégré de santé et de services sociaux de la Gaspésie
Québec

801197

☐ CISSS de la Gaspésie

REFERRAL FORM
AGIR TÔT PROGRAM

*The Agir tôt program is for children **aged 0 to 6 years and 364 days** and their families. It aims to identify indicators of developmental difficulties in children so that they can be directed to the right services quickly.*

Date received at Agir tôt access service : _____

USER IDENTIFICATION

Family name	Name	Date of birth (yyyy/mm/dd)

Sex	Length of pregnancy	Health insurance card number	Expiration (yyyy/mm)
☐ Female ☐ Male ☐ Other :	weeks		

Language spoken	Language(s) understood
☐ French ☐ English ☐ Other :	☐ French ☐ English ☐ Other :

User's address (number, street, city)	Postal code

Living environment

☐ Birth family
*Vulnerability indicators *(check if necessary)* : ☐ Low household income ☐ Socially isolated ☐ No high school diploma or vocational studies
☐ Foster family
☐ First Nation's community
☐ Other :

Professionals involved (if applicable)

☐ **SIPPE-PACE** Name: _____
☐ Doctor/pediatrician Name: _____
☐ Nurse (vaccines) Name: _____
☐ Educator Name: _____
☐ Social worker Name: _____
☐ Daycare Name: _____
☐ School Name: _____
☐ Other: _____

Identify a designated person who can assist the parent in completing the questionnaires (if applicable)

Last name and name	Relationship with the child

Email address	Telephone number

Would you like a second party to complete the questionnaires based on their own observations? ☐ Yes ☐ No

Educator: _____
Teacher: _____

CONTACT INFORMATION FOR PARENTS OR LEGAL GUARDIAN (IF APPLICABLE)

Parental authority

Last name and name		Last name and name	
	☐ Mother ☐ Father ☐ Legal guardian		☐ Mother ☐ Father ☐ Legal guardian
Email address		**Email address**	
Address (if different from user)		**Address (if different from user)**	
Postal code	**Telephone number**	**Postal code**	**Telephone number**

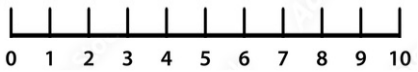
Last name: _____ First name: _____ File #: _____

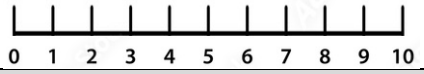
REFERENCE

Concerns leading to referral to Agir tôt program's service's

Parent and referrer expectations related to the request

Level of concern of parent and referrer (0 = Not at all concerned to 10 = Very concerned)

Parent: 

Referrer: 

Diagnosis and associated conditions (if any)	**Date of onset or event**	
Name of referrer	**Telephone number**	**Extension**
Profession	**Establishment**	
Email address		

PARENTAL CONSENT (MANDATORY)

The child's parent or legal guardian has been informed and consents to the request for services and screening if needed?

☐ Yes ☐ No

The parent or legal representative of the child, after having been informed, consents to the attending physician being informed of the request, the evolution and the orientation of the screening if needed?

☐ Yes ☐ No

_____ _____
Signature of parent or of legal representative Date

_____ _____
Signature of referrer Date

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