Lii Michif Otipemisiwak
Family and Community Services
Michif Supported Child Development

Family Intake for MSCD Services
Birth to six Years

Revised March 3, 2026

SECTION 1 – FAMILY INFORMATION

Child/Youth information:

Child's Name/Pronoun:	**Date of Birth:**
PHN #	**Allergies:**
School attending/Grade:	**Other:**
Siblings and ages:	

Family Information:

Mother's (Maamaa) Name/Pronoun:	**Father's (Paapaa) Name/Pronoun:**
Caregiver(s):	**Address(es):**
Phone:	**Phone:**
Email:	**Email:**
Other:	
Where does the Child/Youth Currently Reside:	
Name:	**Relationship:**
Phone:	**Other:**
Email:	

Date of Referral:
Referred by (clearly print full name)**:**
Existing Open File: **CS** **FS** **RE** **ECD only** **CYMH only**
Case Manager: (clearly print full name):
ECD Screening attached: Y/N
Assessment attached or completed on this form: Y/N
Safety Planning Worksheet attached: Y/N

LA PARAANTII

Which people do you identify as your support circle, for yourself, your family, and your children:

LA PARAANTII	
Natural Supports	Community Supports
∞ Name Relationship: Contact:	∞ Name Role: Contact:
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GENOGRAM FURTHER DEVELOPED FROM SCREENING

SECTION 2 – BIRTH AND HEALTH HISTORY:

Birth history and health information:

Hospital baby was born	
Did you have a natural birth or c-Section?	
Birth weight	
Gestational age:	
Any complications during labor? If so, please explain.	
Specific post-natal care	
Delivering Doctor or midwife:	
Other:	

General Health
1.Tell me about what your child/youth's physical health has been like? Any recent hospitalizations or significant illness? 2.Does your child have a medical or developmental diagnosis? Please explain: ❑ Yes ❑ No 3. Is your child taking any medication? If so, fill medication chart below: ❑ Yes 3a. Would the medication need to be taken at school or during community program? *If so, please complete medication administration form.* ❑ Yes ❑ No

3b. Does your child take medication independently or are there any challenges with taking medication? Please explain:

- ❑ Yes
- ❑ No

List all Current Medications, Vitamins, Additives and Herbal Supplements			
Medication	Dose	Reason or Purpose	Result/Effect

SECTION 3– INDIVIDUAL SERVICE TEAM MEMBERS:

Community Team Members:

Role	NAME	CONTACT INFO	NOTES
Parent(s)			
One to One Worker:			
Occupational Therapist/Physiotherapist:			
Speech & Language Therapist:			

School or Daycare: (Name all professionals involved			
Family Doctor/Nurse practitioner:			
Pediatrician:			
Child Psychiatrist:			
Has your child had the following tests or screenings:	Vision:	Hearing:	Dental:
Other:			

LMO Internal care team:

TEAM ROLE	NAME	CONTACT INFO	NOTES

Family History:

Family History – why has child/family been referred to ECD (including any history or past worries)
Why has the family been referred, and what are the identified goals? Use case manager's scaling, next steps and goals for ECD role.

SECTION 4 - CHILD DEVELOPMENT AND SUPPORT NEEDS

Getting to Know You and Your Child - Refer to ECD Screening.

Communication	❑ No concerns ❑ More Information/Support
Gross Motor	❑ No concerns ❑ More Information/Support

Fine Motor	❑ No concerns ❑ More Information/Support
Social/Emotional	❑ No concerns ❑ More Information/Support
Adaptive	❑ No concerns ❑ More Information/Support
Health/Medical *(any information you want to share about your child's health or medical needs and how those needs are being addressed)*	❑ No concerns ❑ More Information/Support
Development worries	

Are you concerned about any of the following:

- *Do you have a family history of hearing loss?*
- *Is your child growing and gaining weight?*
- *Does your child get sick often?*
- *Is your child immunized?*
- *Does your child require any medications or supplements?*
- *Is your child frequently constipated?*

What is your biggest worry about your child's development?	
Developmental Goals and Next Steps:	❑ ASQ-3 monitor ❑ ASQ-SE-2 monitor ❑ DAYC-2 assessment ❑ NTS Developmental Service Plan ❑ Referral to Early intervention therapy (SLP, OT, PT) ❑ Pediatrician referral ❑ Audiology referral ❑ Daycare/Preschool support ❑ Referral to MSCD ❑ Direct support worker ❑ CYMH ❑ Kindergarten transition planning referral
Other include complicating factors:	❑ No concerns ❑ More Information/Support

SECTION 5 – Home Visit Activities and Priorities

Home Visit Frequency:

- ❑ Once per week (4 x per month)
- ❑ Once every two weeks (2 x per month)
- ❑ Once every month (1 x per month)

The following day and time would work best for us: _____

During Home Visits, we would like information about:

- ❑ My child's development
- ❑ How to play with or talk to my child
- ❑ What to feed my child
- ❑ My child's behavior
- ❑ How to care for my child's teeth
- ❑ Toileting, potty training
- ❑ How to prepare my child for daycare, preschool or kindergarten
- ❑ Learning about our Michif language and culture
- ❑ General Parenting Topics
- ❑ Screening and assessments –*Ages and Stages, DAYC-2*
- ❑ Sleep routines
- ❑ Other services that are available for my child
- ❑ Other_____
  _____
  _____

Our family would also like support/information:

- ❑ Scheduling medical, dental, vision, or hearing check-up's
- ❑ Access other services_____
- ❑ Learning about our Michif language and culture

Upcoming LMO groups or community events that may interest our family:

- ❑ Beading circle
- ❑ Children Are Our Medicine
- ❑ Michif Circle of Security Parenting
- ❑ Lii Vii Maykiw Perinatal support
- ❑ Lii Petit Wapososak Breakfast group
- ❑ Infant massage
- ❑ LMO Kitchen Party and Events
- ❑ Michif Elder

For Consultant only

Michif community connection:

Métis citizenship: Y/N
Connected to Two Rivers Métis society: Y/N
Registered for MNBC family connections: Y/N
Add family to LMO reception distribution list: Y/N
Add family to LMO Cultural list (Fill out referral to cultural worker): Y/N

Next Steps refer to training binder:
Piihtikway Honoring
Michif Child Development Plan
Family Wellness Plan
Ongoing monitoring and plan review
ICM meetings

	Signature:	Date:
MSCD/MIDP Consultant:		
Parent/Guardian		
Michif Early Years Manager:		