Fraser Valley Child Development Centre

REFERRAL FOR SERVICES

Has the parent or legal guardian consented to this referral? ❒ YES ❒ NO
This referral will not be processed without parental/legal guardian consent.

CHILD'S LAST NAME, FIRST NAME ❒ FEMALE ❒ MALE		DATE OF REFERRAL		DATE OF BIRTH (DD/MM/YYYY)
FIRST LANGUAGE (*If not English*)	INTERPRETER REQD. ❒ YES ❒ NO	HOUSE ADDRESS (WHERE THE CHILD RESIDES)		
ABORIGINAL ❒ YES ❒ NO	PARENT/GUARDIAN/FOSTER PARENT	RELATIONSHIP TO CHILD	LEGAL GUARDIAN Yes ❒ No ❒	PERSONAL HEALTH #
MAILING ADDRESS (If not same as above), POSTAL CODE			HOME PHONE:	WORK PHONE/CELL:
NAME OF PRESCHOOL, DAYCARE, SCHOOL	CONTACT NAME	PHONE NO:	PHYSICIAN:	
SOCIAL WORKER NAME:		PHONE #	FAX #	
ADDRESS:		POSTAL CODE:	EMAIL ADDRESS:	
REASON FOR REFERRAL:				
MEDICAL DIAGNOSIS: ❒ YES ❒ NO – IF YES, SPECIFY:				
HOME VISIT OR HEALTH/SAFETY CONCERNS: ❒ YES ❒ NO – IF YES, SPECIFY:				
REFERRED BY (Please print name):		PHONE #		
RELATIONSHIP AND/OR FACILITY		ADDRESS/POSTAL CODE		
FORM COMPLETED BY:		ORIGINAL DATE OF REFERRAL (DD/MM/YY):		

The private and personal information collected on this form is used to determine eligibility and appropriateness of services to be provided. Nonidentifying statistical information may be collected, collated and distributed to support requests for funding, advocacy, resource allocation and measuring outcomes. Please refer to the Fraser Valley Child Development Centre Personal Information Protection Act Policy.

Revision date: August 19, 2009

Abbotsford Office
102-32885 Ventura Ave
Abbotsford, BC
V2S 6A3
Tel: (604) 852-2686
Fax: (604) 852-5794

Chilliwack Office
45474 Luckakuck Way
Chilliwack, BC
V2R 3S9
Tel: (604) 824-8760
Fax: (604) 824-8735

Hope Office
1250 7th Ave
Hope, BC
V0X 1L0
Tel: (604) 869-5467
Fax: (604) 869-2994

Mission Office
4-7337 Welton St
Mission, BC
V2V 3X1
Tel: (604) 820-9536
Fax: (604) 820-9568

Website: www.fvcdc.org

FRASER VALLEY CHILD DEVELOPMENT CENTRE

SCHOOL-AGE REFERRAL FOR SERVICES
Current CDC Clients ONLY

Anyone may refer to the Centre and request services on behalf of a child.

Has the parent or legal guardian consented to this referral? ☐ yes ☐ no
This referral will not be processed without parental/legal guardian consent.

DATE OF REFERRAL

CHILD'S LAST NAME	FIRST NAME

DATE OF BIRTH (DD/MM/YY)	GENDER ☐ FEMALE ☐ MALE	PHN #

IF YOUR PERSONAL INFORMATION HAS CHANGED RECENTLY, PLEASE COMPLETE THIS SECTION. IF YOUR INFORMATION REMAINS THE SAME, PLEASE GO TO THE NEXT SECTION

ADDRESS	POSTAL CODE

HOME PHONE NUMBER	PARENT WORK NUMBER	OTHER CONTACT NUMBER (IF APPLICABLE)

PARENT/GUARDIAN NAMES	RELATIONSHIP TO CHILD

NAME OF SCHOOL	PHONE NUMBER

SOCIAL WORKER NAME	PHONE NUMBER

SOCIAL WORKER ADDRESS	POSTAL CODE

REASON FOR REFERRAL (check all that apply)

- ☐ attention/concentration
- ☐ self-care
- ☐ sensory issues
- ☐ fine motor (small muscle and hands)
- ☐ gross motor (large muscle development)
- ☐ perceptual/cognitive
- ☐ feeding
- ☐ special equipment/seating
- ☐ splinting and casting

PROGRAMS

- ☐ Physical Therapy
- ☐ Occupational Therapy
- ☐ Seating Clinic

REFERRAL SOURCE NAME	PHONE NUMBER

ADDRESS	POSTAL CODE

RELATIONSHIP OF REFERRAL SOURCE TO CHILD

OTHER COMMENTS OR CONCERNS:

Signature of Parent/Legal Guardian:

102-32885 Ventura Avenue **Abbotsford, BC V2S 6A3** **Ph: (604) 852-2686 Fax: (604) 852-5794**
45474 Luckakuck Way **Chilliwack, BC V2R 3S9** **Ph: (604) 824-8760 Fax: (604) 824-8735**

Fraser Valley
Child Development Centre

Occupational Therapy/Physical Therapy Consultation

Date of Request: _____ OT Consult:_____ PT Consult:_____

Name of Child: _____ Date of Birth: _____ Age:____

Legal Guardian: _____ Phone: _____

Foster Parent: _____ Phone: _____

School Name/Address: _____ District: _____

Medical Diagnosis/MOE Classification: _____

Reason for Consultation Request:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Other Services Provided by the FVCDC: _____

_____ _____

Signature of Source of Referral Signature of Special Needs Coordinator

Helping Kids Shine

Abbotsford Office
102–32885 Ventura Ave.
Abbotsford, BC V2S 6A3
Tel: 604.852.2686
Fax: 604.852.5794

Chilliwack Office
45474 Luckakuck Way
Chilliwack, BC V2R 3S9
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Hope Office
Unit E13 - 895 Third Ave.
Hope, BC V0X 1L0
Tel: 604.863.0017
Fax: 604.863.0019

Mission Office
4–7337 Welton St.
Mission, BC V2V 3X1
Tel: 604.820.9536
Fax: 604.820.9568

www.fvcdc.org

Fraser Valley
Child Development Centre

CONSENT FOR SERVICE

I, the undersigned parent or guardian of the child _____,

PHN # _____ Date of birth: _____,

do hereby consent to his/her assessment, treatment and/or other service provided by the Fraser Valley Child Development Centre. I understand that the FVCDC's model of service requires parents/guardians to become actively involved in enhancing and enriching their child's development.

No identifying statistical information may be collected, collated and distributed to support requests for funding, advocacy, resource allocation and measuring outcomes.

I will be informed of any assessment findings and will participate in setting specific goals for my child's continued service as required.

☐ Yes ☐ No I am aware that from time to time the Centre will have practicum students, and I agree to have practicum students participate in my child's therapy program.

☐ No Check here if you do **NOT** want your name added to the FVCDC mailing list to receive e-mails, newsletters and information regarding other FVCDC special events and activities.

_____ _____
Date Signature

_____
Printed Name

_____
Printed Address

_____
Postal Code

_____
E-mail Address

_____
Phone Numbers (Home and Work)

_____
Witness (a non-family member please)

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Consent to Obtain/Release Information

By completing this form, you are giving FVCDC consent (as indicated) to collect, use and disclose information for the purposes of providing appropriate assessment(s) and service(s) to your child.

Please initial and give the name and address of all pertaining persons/agencies.
By signing this consent to obtain/release information, it will VOID ALL PREVIOUS CONSENTS on file.

Initials Only Obtain	Release			FVCDC Staff Use Please check if Admin to obtain info
____	____	School District (**must specify**)	School Name _____	☐
____	____	Private School (**must specify**)	Private School Name: _____	☐
____	____	Preschool (**must specify**)	Name: _____ Address: _____	☐
____	____	Daycare (**must specify**)	Name: _____ Address: _____	☐
____	____	Supported Child Development Program (**must specify** if other than FVCDC)	Name: _____ Address: _____	☐
____	____	Child Development Centre (**must specify** if other than FVCDC)	Name: _____ Address: _____	☐
____	____	Infant Development Program (**must specify** if other than FVCDC)	Name: _____ Address: _____	☐
____	____	BC Women's & Children's Health Centre		☐
____	____	Sunny Hill Health Centre		☐
____	____	Health Unit _____	_____	☐
____	____	My Child's Physician(s) (**must specify family physician or specialist**)		
		Name: _____ Address: _____	Name: _____ Address: _____	☐
____	____	Ministry of Child & Family Development (**must specify**)	Name: _____ Address: _____	☐
____	____	Other (**must specify**)		
		Name: _____ Address: _____	Name: _____ Address: _____	☐

_____
Name of Child

_____
Child's Birth Date

_____
PHN Number (care card)

_____
Date

_____
Signature of Parent/Legal Guardian authorized to give consent

_____
Relationship to Child

_____
Address

_____

_____
Signature of Witness

FVCDC Forms- July 2007

The Fraser Valley Child Development Centre 45474 Luckakuck Way, Chilliwack, BC V2R 3S9
Telephone: (604) 824-8760 Fax: (604) 824-8735