REQUEST FOR SERVICE: PHYSICIAN/HEATHCARE PROVIDER

Early Intervention Therapy (EIT) Program

2805 Kingsway, Vancouver, BC V5R 5H9
Tel: 604.451.5511 Fax: 604.451.5651 Web: www.bc-cfa.org

Section 1 – Child Information (PLEASE PRINT)

MSP PERSONAL HEALTH NUMBER	CHILD'S FIRST NAME	CHILD'S LAST NAME

DATE OF BIRTH (DD/MM/YYYY)	CHILD'S GENDER	NAME OF PARENT OR GUARDIAN (FIRST AND LAST)
	◉ Male ○ Female ○ Other	

ADDRESS	CITY	POSTAL CODE	INTERPRETER NEEDED
			☐ YES ☐ NO LANGUAGE:

HOME TELEPHONE	MOBILE	EMAIL

Section 2 – Information

DIAGNOSIS	RELEVANT MEDICAL HISTORY

SERVICES REQUESTED

☐ PT _____
☐ OT _____
☐ SLP _____
☐ FEEDING _____

OTHER REFERRALS INITIATED (DD/MM/YYYY)

☐ IDP ☐ HEALTH UNIT SLP DATE: ☐ VCH PT (North Shore Only)	☐ Private ASD Assessment ☐ PARC DATE: ☐ CDBC

SECTION 3 – REQUIRED DOCUMENTATION

TO AVOID DELAYS PLEASE ENSURE WE RECEIVE:

- ☐ Relevant consultation reports/letters/growth charts (physicians, therapists)
- ☐ For **Infant feeding support**, a documented feeding plan and growth charts, if possible, **MUST** be attached
- ☐ Parent signature for agreeing to the referral and consenting to the exchange of verbal information
- ☐ Consent to Obtain/Release Information (page 2)

TO EXPEDITE SERVICE:

The BC Centre for Ability also requires a Parent Request for Service. Please download the form from the BCCFA website or direct families to **www.bc-cfa.org** where they can download the form or they may contact the Centre to obtain the form.

SECTION 4 – Parent/Legal Guardian Consent (REQUIRED)

I, _____ (*Parent Name*), parent/guardian of _____ (*Child Name, Date of Birth*) agree to this referral and hereby authorize the exchange of verbal information with the referring person/agency for the purposes of initiating and clarifying services for my child.

SIGNATURE	DATE

SECTION 5 – Referring Physician Or health Care Provider

REFERRING AGENCY	REFERRING PERSON

DISCIPLINE	PHONE	FAX
☐ MD ☐ PT ☐ OT ☐ SLP ☐ CHN		

ROUTING PATH: REFERRING PROVIDER →EIT PROGRAM INTAKE →FILE

Revision 2018 September

BC Centre for Ability
Beyond challenges—the sky's the limit

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Child's Name: _____ _____ DOB: _____
(* PLEASE PRINT *) Family Name First Name

BC CENTRE FOR ABILITY CONSENT TO OBTAIN/RELEASE INFORMATION

Consent to *Obtain* **Please INITIAL**	Consent to *Release* **Please INITIAL**	**To provide safe, effective, coordinated services BC Centre for Ability staff need to request and share information with your child's other service providers. All information is treated as strictly confidential. A copy of this consent will be sent to all persons/agencies when information is requested from them. BCCFA reports are always sent to parent(s) and/or legal guardians. Current Providers (a change in provider will not negate general consent)**			
		Family Physician		Name:	Phone:
		Pediatrician		Name:	Phone:
		Infant Development Program		Name:	Phone:
		Supported Child Development Program		Name:	Phone:
		Foster Family		Name:	Phone:
		Ministry of Children & Family Development		Child/Youth With Special needs (CYSN)	At Home Program (AHP)
		Health Unit Services	SLP	Name:	Phone:
			AUDIOLOGY	Name:	Phone:
			PT	Name:	Phone:
			CHN	Name:	Phone:
		BC Women's and Children's Hospital, SunnyHill Health Centre, Royal Columbian Hospital		Name:	Phone:
		Other:		Name:	Phone:

PLEASE NOTE: BOTH LEGAL GUARDIANS MAY BE REQUIRED TO SIGN CONSENT FORMS. CONSENT EXPIRES 1 YEAR FROM SIGNING.

I, the undersigned legal guardian for **(child's name)** _____, DOB: _____ do hereby authorize the BC Centre for Ability to obtain information from and release information to the persons/agencies as indicated above.

X _____ **X** _____ **X** _____
Signature of Legal Guardian ***Please Print Name*** ***Relationship to Child***

X _____ **X** _____
Signature of Witness (must be 18 yrs or older) ***Date***