REQUEST FOR SERVICE

Early Intervention **Program** (EIP) Tel: 604.451.5511 Web: www.bc-cfa.org

Completed forms can be sent by:
Email: EITAdmin@bc-cfa.org
Fax: 604-451-5651
Mail: 2805 Kingsway, Vancouver, BC V5R 5H9

Section 1 - Child Information

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

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

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

HOME TELEPHONE	MOBILE	EMAIL

PREFERRED METHOD OF CONTACT	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 - Referral Source

REFERRING PERSON	REFERRING AGENCY

RELATIONSHIP TO CHILD	PHONE	FAX

SECTION 4 - Completion Checklist

The legal guardian has agreed to this referral

Consent to Obtain/Release Information (page 2) is completed

Relevant consultation reports/letters/growth charts are included

Beyond challenges—the sky's the limit

BC Centre for Ability

BC CENTRE FOR ABILITY CONSENT TO OBTAIN/RELEASE INFORMATION

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.

Child's Name: ______________________ ______________________ **DOB:** ______________

Family Name First Name

I, **__________________________, (Legal Guardian)** authorize the BC Centre for Ability to obtain and release medical/education information and verbally share information regarding my child with each other, as well as with persons/agencies listed below. **Please add an x in the column beside the person/agencies you wish to consent to obtain and release information about your child.**

Date: ______________________

X	Persons/Agencies	Contact Information
	Family Physician	
	Pediatrician	
	Infant Development program	
	Preschool/Daycare	
	Foster Family	
	Ministry of Child and Family Development	
	Health Unit Services	
	Early Childhood Mental Health	
	Alan Cashmore Centre or Pace program	
	BC Early Hearing Program	
	Behavioural Consultant or Interventionist(s)	
	BC Children's and Women's Hospital and Sunnyhill Health Centre	
	Other Hospitals (please specify)	
	Private Therapy Services (please specify)	
	School District	
	Other BCCFA programs (Supported Child Development Program, Early Intervention Therapy, Stepping Stones, Key Worker Program, Family Counselling)	
	Supported Child Development	
	Other (please specify)	