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	NAME OF PARENT OR GUARDIAN (FIRST AND LAST)
	◉ Male ○ Female ○ Transgender ○ Gender Fluid ○ Other	

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

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)	