# Children's Therapy and Family Resource Centre

801 McGill Road, Kamloops, BC V2C 6R1 Phone: (250) 371-4100 Fax: (250) 371-4120
www.kamloopschildrenstherapy.org

## Referral Form – School Age
**(Please complete all 3 pages)**

| | | | |
|---|---|---|---|
| Last Name | First Name | Middle Name | Also Known As |
| Date of Birth (MM/DD/YY) | Age at Referral | Gender ___ Male ____ Female | Physician |

| | | |
|---|---|---|
| Parent/Caregiver Name(s) | Relationship to Child | |
| Address *(street address)* | City | Postal Code |
| Address *(mailing address if different from above)* | City | Postal Code |

| | | | |
|---|---|---|---|
| Home Phone Number | Work Phone Number | Cell Phone number | Email Address |

| | | |
|---|---|---|
| Legal Guardian Names(s) (*if different from parent or caregiver)* | Relationship to child | Phone number |
| Legal Guardian Address *(street address)* | City | Postal Code |

| | |
|---|---|
| Name of Preschool, Daycare, School etc. | Grade |
| First Nations/Aboriginal Ancestry ____ Yes ____ No | Band Name |

| | | |
|---|---|---|
| Allergies ____ Yes ____ No | Details of Allergies | Special Precautions |

| | | | |
|---|---|---|---|
| Personal Health Number | Primary Spoken Language | Primary Written Language | Interpreter Required ____ Yes ____ No |

Who can refer? Anyone (Parents, Physicians, Daycares, School, etc.) may refer to our centre (with legal guardian's consent.)

**REFERRAL INFORMATION: (Please complete with the family)**

DIAGNOSIS (*if applicable*):

ASSOCIATED CONDITION(S):

RELEVANT HISTORY: *(attach additional reports as necessary)*

FAMILY'S MAIN CONCERN(S):

REFERRALS SOURCE'S MAIN CONCERN(S):

**REFERRAL SOURCE CONTACT INFORMATION**:

(Please note if referral is made by school staff, ***School Therapy Program Referral Checklist*** must also be completed for referral to be accepted)

| Name *(print or type)* | Signature | |
|---|---|---|
| Address | Postal Code | Phone Number |
| Relationship of Referral Source to Child | | |

**LEGAL GUARDIAN'S SIGNATURE** (must be present for referral to be accepted):

| Legal Guardian Signature | |
|---|---|
| Date | Relationship to child |

**PLEASE COMPLETE 3RD PAGE OF REFERRAL (Consent Form – School Age) * MUST BE SIGNED BY LEGAL GUARDIAN***

(Please note if referral is made by school staff, ***School Therapy Program Referral Checklist*** must also be completed for referral to be accepted)

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## School Therapy Program Consent Form

Child's Name: _____ Date of Birth: _____

I, _____ (legal guardian's name), do hereby authorize the staff of the Children's Therapy and Family Resource Centre to provide my child with clinical services.

I hereby authorize the Children's Therapy and Family Resource Centre to obtain and release information relevant about my child, to and from the following agencies/persons.

**(Please initial each applicable box)**

- ☐ At Home Program
- ☐ Autism Diagnostic Team
  (Coordinator, Interior Children's Assessment Network, Psychologist, SLP, OT, Pediatrician)
- ☐ BC Children's Hospital
- ☐ Community Living BC (CLBC)
- ☐ Child and Youth Mental Health
- ☐ Equipment Dealer: _____
- ☐ Family Physician: _____
- ☐ Foster Family: _____
- ☐ Infant Development Program
- ☐ Interior Community Services
- ☐ Ministry for Children and Family Development
- ☐ Orthotics/Prosthetics Services: _____
- ☐ Pediatrician: _____
- ☐ Preschool/Daycare: _____
- ☐ Public Health (IHA)
  (Public Health Nurse, Dietician, Speech Therapist, Audiologist)
- ☐ School District:
  - ☐ # 73 (Kamloops Thompson)
  - ☐ #58 (Merritt)
  - ☐ #74 (Gold Trail)
  - ☐ Other: _____
- ☐ Sunny Hill Health Centre for Children
- ☐ Other Family Members: _____
- ☐ Other Agency/Person: _____

☐ I hereby authorize the staff of CTFRC to help my child with toileting needs as required.

☐ I hereby give my consent to allow audio/visual records to be taken of my child for the following reasons:

- ☐ To be used for the child's treatment. This information may be shared with the child's team.
- ☐ To be used for teaching and workshops. It is understood that the child will not be identified by name. I waive all rights to payment or royalties in connection with any presentation of these photographs/videos now and in the future.
- ☐ To be used by the Children's Therapy and Family Resource Centre now and in the future for public community relations, eg. brochures, display boards, print material and fund raising.

Signature: _____ Date: _____
(Legal Guardian)

Relationship to Child: _____

**This consent is valid until your child graduates from school or until he/she is discharged from the School Therapy Program. Please contact the centre if you wish to make any changes to this consent at any time.**