PARENT REQUEST FOR SERVICE
Early Intervention Therapy (EIT) Program

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

Section I: Child Information (PLEASE PRINT)

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

DATE OF BIRTH (DD/MM/YYYY)	CHILD'S GENDER	CHILD RESIDES WITH
	☐ Male ☐ Female ☐ not specified	☐ Both Parents ☐ Mother only ☐ Father Only ☐ Foster Family ☐ Other

NAME OF PARENT(S) OR Legal GUARDIAN (FIRST AND LAST)
Mother(s): Father(s): Other Guardian:

ADDRESS (where child resides)	CITY	POSTAL CODE

TELEPHONE	WORK/MOBILE	EMAIL

THE LEGAL GUARDIAN FOR THIS CHILD IS:

☐ Both Parents ☐ Mother only ☐ Father Only ☐ MCFD SW ______________ (name) ☐ Other ______________ (please specify)

If applicable - please provide a copy of any legal custody document regarding this child.

PRIMARY LANGUAGE SPOKEN AT HOME	ARE YOU COMFORTABLE COMMUNICATING IN ENGLISH?
☐ English ☐ Other(s) Please list ______________	Spoken ☐ Yes ☐ No Written ☐ Yes ☐ No Would an interpreter be helpful? ☐ Yes ☐ No

Do you self-identify with any Aboriginal or First Nations group? ☐ Yes ☐ No

Are you receiving services at: ☐ Sheway or ☐ Spirit of the Children

Alternate Contact Information

NAME (FIRST AND LAST)	☐ Mother ☐ Father ☐ MCFD SW ☐ Other

ADDRESS	CITY	POSTAL CODE

TELEPHONE	WORK/MOBILE	EMAIL

Medical Information

Does your child have a diagnosis? ☐ No ☐ Yes (please specify) ______________
Please attach any available documentation

OTHER HEALTH CONCERNS: allergies, seizures, etc.

NAME OF CURRENT MEDICATIONS	DATE PRESCRIBED	PURPOSE (seizures, tone management, reflux, etc.)	PRESCRIBED BY	DOSAGE

Has your child been involved with any of these services/clinics:

☐ PARC (autism diagnosis)- SHHC
☐ Complex Developmental Behavior Conditions - SHHC
☐ Private Autism Assessment: *specify name/phone#:*
☐ Feeding-Swallowing Team
☐ Complex Feeding Team - BCCH
☐ Visual Impairment Program
☐ Neurology - BCCH
☐ Muscle Diseases Clinic
☐ Orthopedics

Other Community Services: My child currently receives services or is wait listed for

☐ Infant Development Program (name): ___________________________

☐ Health Unit SLP (name): __________________________

☐ Supported Child Development Program (name): _________________________

☐ Daycare/Preschool (name): ________________________

☐ Community/Public Health Nurse (name): ___________________________________

I understand that to complete the intake process I will be contacted by someone at BCCFA.

I prefer initial contact be made by: ☐ e-mail (please print clearly) _________________________________ ☐ phone ____________________

I understand my signature is authorization to speak with all listed Programs and/or Service Providers named in this referral for purposes of Service Coordination.

Parent/Guardian Signature	Date

Did any professionals assist you in completing this form? If Yes,

Name of Professional	Contact Information

I have also completed the BC CENTRE FOR ABILITY CONSENT TO OBTAIN/RELEASE INFORMATION form (Page 4/4) ☐ Yes ☐ No

I consent to receiving information/newsletters from BCCFA Programs/Foundation by email ☐ Yes ☐ No

SECTION II: Considering your child's AGE, please indicate your child's current areas of need:

MOBILITY

☐ Head control
☐ Tummy Time
☐ Rolling/crawling
☐ Changing position
☐ Sitting
☐ Standing
☐ Walking
☐ Running
☐ Stairs
☐ Jumping
☐ Falls frequently

OUTDOOR SKILLS

☐ Ball skills – throwing/catching/kicking
☐ Bike riding skills
☐ Climbing and use of playground equipment
☐ Managing uneven ground/surfaces
☐ Skills are generally below his/her peers

PLAY AND LEARNING

☐ Cause and effect play (making things happen)
☐ Using 2 hands in play (holding, joining toys)
☐ Holding crayons/markers to colour & make lines
☐ Copying & drawing simple shapes & pictures
☐ Cutting with scissors
☐ Using fingers to manipulate & explore toys
☐ Problem solving how things work (matching, building)
☐ Sitting still to focus on tasks
☐ Taking Turns/sharing
☐ Following routines
☐ Transitioning between activities
☐ Limited range of interests
☐ Pretend Play (e.g. giving teddy a drink, pretending a pillow is a hat)
☐

COMMUNICATION

☐ Eye contact
☐ Babbling or making sounds
☐ Using gestures
☐ Understanding what I say
☐ Following directions
☐ I cannot understand much of what my child says
☐ Others cannot understand much of what my child says
☐ My child has no words
☐ Telling stories or talking about his/her day
☐ Talking with peers/friends
☐ Taking turns during conversations

SELF CARE

Dressing:

☐ Taking off clothes
☐ Arranging & putting on clothing
☐ Managing fasteners
☐ Tolerating clothing textures

Eating and Drinking

☐ Safe oral feeding
☐ Managing reflux
☐ Using utensils and drinking from a cup
☐ Eating a variety of foods and textures
☐ Positioning for eating/drinking
☐ Transitioning safely from tube to oral feeding
☐ Getting enough nutrition from oral feeding

Bathing / Hygiene/Toileting:

- ☐ Face Washing
- ☐ Hair brushing/washing
- ☐ Tooth brushing
- ☐ Hand washing

Toileting:

- ☐ Training readiness
- ☐ Toileting routines
- ☐ Positioning on toilet
- ☐ Getting on /off toilet

Sleeping

- ☐ Bed time routines
- ☐ Falling asleep
- ☐ Staying asleep
- Positioning for reflux

HOME AND COMMUNITY ACTIVIITES

- ☐ Transportation (e.g. car seats, strollers, accessible vans)
- ☐ Accessibility at home, preschool and community (e.g. ramps, washrooms, adapted furniture)
- ☐ Participating in family and social events
- ☐ Participating in leisure, recreation or sports activities

FAMILY / SOCIAL RELATIONSHIPS

- ☐ Making friends
- ☐ Reading social cues
- ☐ Taking turns
- ☐ Showing empathy
- ☐ Managing emotional responses
- ☐ Age appropriate behavior

HELP FOR MYSELF AND MY FAMILY

- ☐ Transitioning to daycare, preschool or kindergarten
- ☐ Meeting other families in a similar situation
- ☐ Adjusting to my/our child's special/extra needs
- ☐ Going through a diagnostic process/medical testing
- ☐ Family relationships (e.g. siblings, extended family, parenting)
- ☐ Accessing resources (e.g. tax credits, financial, housing)

What are you most worried about and how does it impact your child/family's life?

____

____

____

Is there any other additional information you feel is important for us to know?

____

____

____

I would be interested in attending a workshop about:

- ☐ Sleeping
- ☐ Toileting
- ☐ Sensory Eating Challenges
- ☐ Sensory processing
- ☐ Baby Massage
- ☐ Fine Motor Skills for Preschooler
- ☐ Promoting Gross Motor Development
- ☐ Communicating with my child
- ☐ Early Language Development
- ☐ Parent Networking
- ☐ Kindergarten Transition
- ☐ Advocacy
- ☐ Social-Emotional Development

To improve service delivery efficiency, please be aware that you may be offered services/clinic participation/workshops at BCCFA locations in Vancouver, Richmond and/or the North Shore.

If you have not received a letter/email confirming receipt of this referral within 3 weeks of sending – please contact us at 604-451-5511, ask for EIT Admin.

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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:
		Preschool/Daycare		Name:	Phone:
		Stepping Stones		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:
			OT	Name:	Phone:
			PT	Name:	Phone:
			CHN	Name:	Phone:
		Early Childhood Mental Health, Alan Cashmore Centre or Pace Program		Name:	Phone:
		BC Early Hearing Program		Name:	Phone:
		Behavioral Consultant/Interventionist(s)		Name:	Phone:
		BC Women's and Children's Hospital and Sunnyhill Health Centre		Name:	Phone:
		Other Hospitals: • Royal Columbian Richmond Hospital • Burnaby Hospital Lions Gate Hospital Other:		Name:	Phone:
		Private Therapy services	SLP	Name:	Phone:
			OT	Name:	Phone:
			PT	Name:	Phone:
		School District – **Children preparing for Kindergarten entry**		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*

TURN OVER

Your Rights

a) The Right to Information

You have the right to:
- Receive copies of all written reports by the Early Intervention Therapy Team about your child and family.
- See your child's health record at the Centre at anytime by contacting your Regional Coordinator (Please note: In keeping with the *Freedom of Information and Protection of Privacy Act*, the Centre does not make copies of reports originating from other agencies)
- Have complete and unbiased information on assessment, treatment and service options
- Ask questions and receive answers regarding your child's assessment and any aspect of your child's treatment.
- Receive information in a language that you understand. The Centre will provide interpretation services to families as required.
- Information on community resources that may be suitable and available for your child and your family.

b) The Right to Confidentiality

- All staff, volunteers and students at the BC Centre for Ability sign a Confidentiality Agreement when they are hired. Breaches of confidentiality are grounds for discipline by the Centre as well as by professional colleges or registering bodies.
- Information on your child and your family will not be released without your permission

c) The Right to Refuse Services

- The therapy team will explain any service or intervention they propose or recommend including any potential risks. You have the right to refuse any service or intervention you believe is not in the best interests of your child or family

d) The Right to Provide Feedback

- You have the right to express concerns, make complaints or offer compliments. A complaint will not result in the loss of services.

Please see pages 2-3 in the EIT Parent Handbook for further explanations of your rights.

Your Responsibilities

- Please inform staff who are scheduled to visit your home, if you or your child is sick
- Please let staff know if you are unable to keep an appointment or if your child will not be at preschool or daycare at a previously scheduled time.

Please indicate that you have been given information on your rights and responsibilities.

Initial: __________________

Date: ___________________