



Children's Development Centre

1546 Bernard Avenue, Kelowna, BC V1Y 6R9

Phone: 250-763-5100 | Fax: 250-862-8433

Date Received: for office use only:

MCFD Referral and Consent Form

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: <input type="checkbox"/> Male <input type="checkbox"/> Female	CLIENT CODE: for office use:
First Nations/Aboriginal Ancestry: <input type="checkbox"/> Yes <input type="checkbox"/> No Metis: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Referring Social Worker:		Phone number:
Is referring Social Worker Guardian of this child? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, name of Guardian:		Relationship to the child: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other: _____
Address of Guardian:	City:	Postal Code:
Email:	Phone number of Guardian (if different than above):	
Other Social Worker involved:	Phone number:	
Are there any court orders in place or pending? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Service requested		
<input type="checkbox"/> Physical Therapy <input type="checkbox"/> Supported Child Development* <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Infant Development Program <input type="checkbox"/> Speech and Language Pathology		
While Starbright will determine appropriate services, your input will be of significant help.		
*The Supported Child Development (SCD) department provides consultation services and extra staffing assistance to ensure inclusive practices for children who need extra support to be successful in daycares, preschools or out of school care programs. We work with children from birth to age 12. Parents of children over the age of 5 must be working or attending school to qualify for this program.		
Guardian Priorities – Reason for referral		
What are your primary developmental concerns for this child?		
What are your visions/priorities for this child?		

Starbright approval for office use:

Additional Information	
Emergency Contact: <input type="checkbox"/> MCFD <input type="checkbox"/> Foster Parent(s) <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other: _____	
Why is MCFD involved?	
Other medical professionals and/or community services involved:	Phone number:
Daycare/Preschool (if applicable):	Phone number:

Names of Parents (if not Guardians)	
Mother: Involved? <input type="checkbox"/> Yes <input type="checkbox"/> No Include in intake and appointments? <input type="checkbox"/> Yes <input type="checkbox"/> No	Father: Involved? <input type="checkbox"/> Yes <input type="checkbox"/> No Include in intake and appointments? <input type="checkbox"/> Yes <input type="checkbox"/> No
<i>If yes</i> , who is responsible for notifying parent regarding visits?	<i>If yes</i> , who is responsible for notifying parent regarding visits?
Are there any booking concerns or instructions? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please explain:</i>	Are there any booking concerns or instructions? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please explain:</i>
Are there any safety concerns? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please explain:</i>	Are there any safety concerns? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please explain:</i>
Access or visitation information? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please explain:</i>	Access or visitation information? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please explain:</i>
What are the family dynamics?	

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Name of Foster Parents	
Names:	
Address:	City:
Postal code:	Phone number:

Birth Information and Medical History
Pregnancy and birth description: <input type="checkbox"/> Healthy, with no complications <input type="checkbox"/> Complications (<i>please provide medical and health details</i>): Delivery: <input type="checkbox"/> Vaginal <input type="checkbox"/> Caesarean Gestational Age _____ weeks Birth weight (<i>please indicate pounds or kilograms</i>): _____ Was there any known fetal exposure to: Alcohol: <input type="checkbox"/> No <input type="checkbox"/> Yes (Non) prescription drugs: <input type="checkbox"/> No <input type="checkbox"/> Yes (<i>please provide details</i>): Does the child have ongoing health issues: <input type="checkbox"/> No <input type="checkbox"/> Yes <i>If yes, please provide details below:</i> Does the child use medication? <input type="checkbox"/> No <input type="checkbox"/> Yes (please specify) _____ Has the child been seen by a specialist? <input type="checkbox"/> No <input type="checkbox"/> Yes _____ Does the child have a diagnosis? <input type="checkbox"/> No <input type="checkbox"/> Yes _____ Has the child been hospitalized at any time? <input type="checkbox"/> No <input type="checkbox"/> Yes _____ Does the child have any allergies? <input type="checkbox"/> No <input type="checkbox"/> Yes _____ Additional concerns:

Other services	
Does the child receive other early intervention services (e.g. speech, physiotherapy, etc.) from other service providers? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>If yes, please provide details:</i>	
Name of Centre:	Contact person/title

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CONSENT FOR SERVICE

The Ministry of Children and Families (MCFD) gives consent to Starbright Children's Development Centre to:

1. Provide services for the above named child currently "In Care" of MCFD
2. Make the appropriate service referrals within Starbright's realm of services as listed on page 1
3. Use audio/visual technology (for the purpose of recording therapy, assessment and progress only)
4. Take whatever action is deemed necessary, in the case of an emergency, including the administration of First Aid, to ensure the health, well-being and safety of the above child
5. Obtain and/or Release information (verbal and/or written) to the persons or agencies on this page as indicated below.
Please initial in the columns below beside all that apply to indicate your consent.

MCFD understands that records regarding the above named child may be accessed by Starbright Staff. Records may also be reviewed for purposes of accreditation. 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. Starbright reports will be sent to the guardian.

Consent to Release	Consent to Obtain		
		Ministry of Children and Family Development	Name
		Family Physician	Name Phone
		Pediatrician	Name Phone
		Foster Parent(s)	Name Phone
		Mother	Name Phone
		Father	Name Phone
		Interior Health Authority	Name
		Kelowna General Hospital	Name
		Preschool/Daycare	Name Phone
		Interior Health Children's Assessment Network	Name
		Other Community Agencies (e.g. BC Children's Hospital, Sunnyhill Health Clinic, BC Early Hearing Program, etc.)	Name

MCFD understands and agrees that this consent will continue to remain in effect until all services provided to this child by Starbright Children's Development Centre have ended, or until MCFD has changed this consent. MCFD understands they may request to have this Consent Form updated as information changes.

Authorized signature on behalf of MCFD

 Date Signed

Name of Social Worker

CLIENT CODE: For office use:
