Starbright
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: ☐ Male ☐ Female	CLIENT CODE: for office use:
First Nations/Aboriginal Ancestry: ☐ Yes ☐ No		Metis: ☐ Yes ☐ No
Referring Social Worker:		Phone number:
Is referring Social Worker Guardian of this child? ☐ Yes ☐ No If No, name of Guardian:		Relationship to the child: ☐ Mother ☐ Father ☐ 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? ☐ Yes ☐ No		

Service requested

☐ Physical Therapy ☐ Supported Child Development*

☐ Occupational Therapy ☐ Infant Development Program

☐ 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: ☐ MCFD ☐ Foster Parent(s) ☐ Mother ☐ Father ☐ 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? ☐ Yes ☐ No Include in intake and appointments? ☐ Yes ☐ No	**Father:** Involved? ☐ Yes ☐ No Include in intake and appointments? ☐ Yes ☐ No
If yes, who is responsible for notifying parent regarding visits?	***If yes***, who is responsible for notifying parent regarding visits?
Are there any booking concerns or instructions? ☐ Yes ☐ No *If yes, please explain:*	Are there any booking concerns or instructions? ☐ Yes ☐ No *If yes, please explain:*
Are there any safety concerns? ☐ Yes ☐ No *If yes, please explain:*	Are there any safety concerns? ☐ Yes ☐ No *If yes, please explain:*
Access or visitation information? ☐ Yes ☐ No *If yes, please explain:*	Access or visitation information? ☐ Yes ☐ No *If yes, please explain:*
What are the family dynamics?	

CLIENT CODE: For office use:

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

Birth Information and Medical History

Pregnancy and birth description:

☐ Healthy, with no complications ☐ Complications *(please provide medical and health details):*

Delivery: ☐ Vaginal ☐ Caesarean Gestational Age _____ weeks

Birth weight *(please indicate pounds or kilograms):* _____

Was there any known fetal exposure to: Alcohol: ☐ No ☐ Yes

(Non) prescription drugs: ☐ No ☐ Yes *(please provide details):*

Does the child have ongoing health issues: ☐ No ☐ Yes *If yes, please provide details below:*

Does the child use medication? ☐ No ☐ Yes (please specify) _____

Has the child been seen by a specialist? ☐ No ☐ Yes _____

Does the child have a diagnosis? ☐ No ☐ Yes _____

Has the child been hospitalized at any time? ☐ No ☐ Yes _____

Does the child have any allergies? ☐ No ☐ Yes _____

Additional concerns:

Other services

Does the child receive other early intervention services (e.g. speech, physiotherapy, etc.) from other service providers?

☐ No ☐ Yes *If yes, please provide details:*

Name of Centre:	Contact person/title

CLIENT CODE: For office use:

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. Have practicum students observe and/or participate in therapy
5. 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
6. 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: