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:

# Parent Request for Service 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:<br>☐ Male ☐ Female ☐ Custom: | CLIENT CODE: **for office use:** |
| Name of Person(s) child resides with (*First and Last)*: | | |
| Relationship to the child:<br>☐ Both Parents, the child refers to you as: _____ and _____<br>☐ Single parent, the child refers to you as: _____<br>☐ Maternal Grandparent(s), the child refers to you as: _____ and _____<br>☐ Paternal Grandparent(s the child refers to you as: _____ and _____<br>☐ Foster parent(s): the child refers to you as: _____ and _____<br>☐ Other caregiver(s): the child refers to you as: _____ and _____ | | |
| Home Address: | City: | Postal Code: |
| Email: | Home phone number: | Cell Phone number: |
| Are you the legal guardian for this child? ☐ Yes ☐ No is: If no, the Legal Guardian for this child is:<br>☐ Both Parents ☐ Mother Only ☐ Father Only ☐ Maternal Grandparent(s) ☐ Paternal Grandparent(s)<br>☐ MCFD SW (name) _____ ☐ Other: _____<br>*If applicable, please provide a copy of any legal custody document regarding this child.* | | |
| **Alternate Contact Information** | | |
| Name of Alternate Parent or Guardian (*First and Last)* | ☐ Mother ☐ Father ☐ MCFD SW ☐ Foster parent<br>☐ Other: _____ | |
| **Parent / Guardian Priorities – Reason for referral** | | |
| What are the <u>most important issues</u> that you hope will be addressed with your child? | | |

**Starbright approval**
for office use:

**Cultural Information** (optional)

**Do you wish to self-identify your child as**: *If not applicable, please skip this section*

First Nations/Aboriginal Ancestry ☐ No ☐ Yes Metis ☐ No ☐ Yes

Other self-identified culture? ☐ No ☐ Yes *If yes, please describe:* _____

**Additional Information**

| | |
|---|---|
| Daycare/Preschool ( if applicable): | Phone number: |
| Primary Language Spoken at Home:<br>☐ English ☐ Others: (please list) | Are you comfortable communicating in English?<br>Spoken: ☐ Yes ☐ No Written: ☐ Yes ☐ No<br>Would an interpreter be helpful? |

**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 alcohol: ☐ No ☐ Yes

Was there any known fetal exposure to prescription drugs: ☐ No ☐ Yes *(please provide details):*

Was there any known fetal exposure to non-prescription drugs: ☐ No ☐ Yes *(please provide details):*

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

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

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

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

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

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

Additional details:

**Hearing:** *If not applicable, please skip this section*

Was hearing tested at birth? ☐No ☐ Yes *If yes, were any of the following recommended:*

- follow-up and/or monitoring ☐ No ☐ Yes
- a hearing device ☐ No ☐ Yes

History of ear infections? ☐ No ☐ Yes *(please provide details):*

**Vision:** *If not applicable, please skip this section*

Has vision been tested? ☐ No ☐ Yes *If yes, was the following recommended:*

- follow-up and/or monitoring ☐ No ☐ Yes

**CLIENT CODE:** For office use:

**Development Information**

**Feeding:** *If not applicable, please skip this section*

Currently breastfeeding: ☐ No ☐ Yes

Is feeding a concern (picky eater, coughing or choking during meals)? ☐ No ☐ *Yes If yes, please provide details:*

*We are attempting to streamline services and work in collaboration with the Feeding and Swallowing Team at Kelowna General Hospital (KGH).*

Have you, or will you receive support from the KGH Feeding and Swallowing Team? ☐ No ☐ Yes

Do you consent to Starbright sharing information with the KGH Feeding and Swallowing Team? ☐ No ☐ Yes

**Activities of Daily Living:** *If not applicable, please skip this section*

Please check any of the following activities with which you have concerns:

☐ dressing ☐ bathing ☐ tooth brushing ☐ having face washed

**Sleeping:**
Are there concerns with sleeping? ☐ No ☐ Yes *If yes, please provide details:*

**Communication:** *If not applicable, please skip this section*

Are there concerns with communication? ☐ No ☐ Yes *If yes, please answer questions below:*

How old was your child when s/he began to do each of the following:

Babbling _____ First word (other than momma, dada)_____

How many words does your child use right now? _____

Does your child combine words? ☐ Not yet ☐ Yes Does your child use sentences? ☐ Not yet ☐ Yes

Please give some examples:

Do **you** find your child difficult to understand? ☐ No ☐ Yes

Do **others** find your child difficult to understand? ☐ No ☐ Yes

Is your child able to follow simple/familiar instructions? ☐ Not yet ☐ Yes

Is your child able to follow complex/multiple instructions? ☐ Not yet ☐ Yes E.g. "Take the toy to your room and bring me the book."

*To prevent duplication of services, we work in partnership with the Speech and Language Department at Interior Health. In order to move forward with your child's referral, please confirm your agreement for Starbright to share the information regarding the request for Speech and Language services with the Speech and Language Department at Interior Health.*

Do you consent to Starbright sharing information with the Speech and Language Department at Interior Health: ☐ No ☐ Yes

**CLIENT CODE:** For office use:

**Large muscle movement (sitting, crawling, walking)** *If not applicable, please skip this section*

Do you have concerns with large muscle movement? ☐ No ☐ Yes *If yes, please answer questions below :*

Area of concerns:

How old was your child when s/he began to do each of the following:

Rolling _____ ☐ Not Yet Sitting _____ ☐ Not Yet

Crawling _____ ☐ Not Yet Walking _____ ☐ Not Yet

**Small muscle movement (fingers, hands)** *If not applicable, please skip this section*

Do you have concerns around fine motor development? ☐ No ☐ Yes *if yes, please describe:*

**Interaction with People and Environment:** *If not applicable, please skip this section*

Each child reacts to things around them differently. Please tell us how your child responds to:

- Touch (may really like or dislike certain touch or textures.)
- Sounds (what are the sounds your child loves to hear or does not like to hear?)
- Movements (what movements or actions make your child happy or unhappy?)
- Watching or seeing things (does your child seem to notice things as you might expect?

Does it sometimes take longer than you might expect for your child to settle when upset?

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

What things will help your child calm or settle (e.g. toys, blanket, being by him/herself, soother, being held, rocking him/herself back and forth)?

Please describe your child's favorite toys or play activities:

**CLIENT CODE:** For office use:

Do you have concerns with how your child transitions from one activity or situation to another?

☐ Not applicable ☐ I am not sure ☐ No ☐ Yes *If yes, please give details:*

When other children are around, my child typically:

☐ shows an interest and interacts ☐ shares ☐ plays beside them but not with them ☐ tends to play on own

How would you describe your child's personality?

Has your child experienced an episode or period of high stress? ☐ No ☐ Yes *If yes, please provide details:*

| Other services | |
|---|---|
| Does your child receive other complementary services (e.g. speech, physiotherapy, naturopathy, massage, chiropractor, acupuncture, reflexology, etc.) from other service providers?<br>☐ No ☐ Yes *If yes, please provide details:* | |
| Name of Centre: | Contact person/title |
| Name of Centre: | Contact person/title |

If offered, I would be interested in attending a workshop about:

☐ Positive parenting strategies
☐ Stress management for parents
☐ Children's anxiety
☐ Infant Massage
☐ Children's speech development
☐ Sensory – motor regulation
☐ Play group (parent/child)
☐ Self-advocacy
☐ Daily activities (e.g. toileting, sleeping, eating, etc)
☐ Sign Language
☐ Other: _____

**CLIENT CODE:** For office use:

**CONSENT FOR SERVICE**

I understand that when this request for service is received, I will be contacted by someone at Starbright Children's Development Centre.

I prefer to be contacted to schedule appointments by *(you may check more than one)*:
☐ Email (*Please provide email address on Page 1)* ☐ Telephone

I prefer to receive written information and correspondence about my child by *(you may check more than one)*:
☐ Email (*Please provide email address on Page 1)* ☐ Regular mail

If you choose the email option, please remember the following:

*For our clients and their families: Please know that there is always a risk that email may be intercepted between the sender and the receiver. Starbright Children's Development Centre does not use email for confidential information unless that mode of communication is specifically requested by the client/family. Email is not secure, nor is it confidential. If you continue to use email communication, it means that you accept this risk. If you feel that email communication is insufficiently secure for the confidential information you wish to communicate, please call our office by telephone.*

- If you are not self-referring, do we have your permission to contact the referral source? ☐ No ☐ Yes
- Do you agree to have practicum students observe and/or participate in therapy? ☐ No ☐ Yes
- Do you agree that Starbright Children's Development Centre may use audio/visual technology (for the purpose of recording therapy, assessment and progress only)? ☐ No ☐ Yes
- Would you like to receive Centre information such as newsletters and surveys? ☐ No ☐ Yes
- In the event of an emergency, do you agree the Centre should take whatever action is deemed necessary, including the administration of First Aid, to ensure the health, well-being and safety of your child?
  ☐ No ☐ Yes
- Are there any other contacts we can call in case of an emergency?
  ☐ No ☐ Yes *If yes, please provide details:*

| EMERGENCY CONTACT NAME | HOME PHONE NUMBER | CELL PHONE NUMBER | RELATIONSHIP TO CHILD |
|---|---|---|---|
| | | | |
| | | | |

**CLIENT CODE:** For office use:

## Starbright Children's Development Centre Consent to Obtain/Release Information:

*Please **indicate** in the columns below all providers for which you give consent*

| I choose to consent to **release** information to the following: | I choose to consent to **obtain** information from the following: | To provide safe and effective services for your child, Starbright staff may need to request information from, 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. Starbright reports will be sent to the parent(s) and/or guardian(s). | | |
|---|---|---|---|---|
| | | Family Physician | Name | Phone |
| | | Pediatrician | Name | Phone |
| | | Preschool/Daycare | Name | Phone |
| | | Ministry of Children and Family Development (MCFD) | Name | |
| | | Public Health Nurse (IH) | Name | |
| | | Kelowna General Hospital | | |
| | | Children and Youth wilth Special Needs | | |
| | | Interior Health Children's Assessment Network (IHCAN) | | |
| | | Okanagan Ability Centre | | |
| | | BC Children's Hospital (Please check all that apply) | ☐ Neurology ☐ Orthopedics ☐ Cardiology ☐ Genetics ☐ Epilepsy<br>☐ Muscle Diseases ☐ Oncology ☐ Bio Chem Disease<br>☐ Complex Feeding Team ☐ Feeding Swallowing Team | |
| | | Sunnyhill Health Clinic (Please check all that apply) | ☐Assessment ☐ Visual Impairment Team<br>☐Assistive Technology ☐ Positioning and Mobility Team<br>☐Hearing Loss Team ☐ Complex Developmental Behaviour Conditions | |
| | | Other: | | |

I authorize Starbright Children's Development Centre to obtain and/or release information regarding my child

Child's NAME: _____, DOB: _____ from the persons/agencies listed above.

I understand and agree that this consent for service (pg 6) and this consent to obtain/release information, will continue to remain in effect until all services provided to my child or children by Starbright Children's Development Centre have ended, or until I have changed this consent. I understand I may request to have my Consent Form updated as information changes.

X _____ _____ _____

Signature of Legal Guardian | Printed Name of Legal Guardian | Relationship to the Child

X _____

Date:

**CLIENT CODE:** For office use: