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: ☐ Male ☐ Female	CLIENT CODE: for office use:

Child Resides with:

☐ Both Parents ☐ Mother Only ☐ Father Only ☐ Maternal Grandparent(s) ☐ Paternal Grandparent(s)

☐ Foster Family ☐ Caregiver(s) ☐ Other: _____

Name of Person(s) child resides with (*First and Last)*

Home Address:	City:	Postal Code:
Email:	Home phone number:	Cell Phone number:

The Legal Guardian for this child is:

☐ Both Parents ☐ Mother Only ☐ Father Only ☐ Maternal Grandparent(s) ☐ Paternal Grandparent(s)

☐ MCFD SW (name) _____ ☐ Other: _____

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 ☐ Other: _____

Parent / Guardian Priorities – Reason for referral

What are the <u>most important issues</u> that you hope will be addressed with your child?

Do you feel you have adequate support from others (family, community) right now?

Starbright approval
for office use:

Cultural Information (optional)

Do you wish to self-identify your child as:

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

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

Please describe any cultural or religious beliefs and values that you'd like us to be aware of in providing services to your child:

Additional Information

Does your child have siblings? ☐ No ☐ Yes

Daycare/Preschool (if applicable):	Phone number:
Primary Language Spoken at Home: ☐ English ☐ Others: (please list)	Are you comfortable communicating in English? Spoken: ☐ Yes ☐ No Written: ☐ Yes ☐ No 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 to: Alcohol: ☐ No ☐ Yes

(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:

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):*

CLIENT CODE: For office use:

Vision:

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

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

Development Information

Feeding:

Currently breastfeeding: ☐ No ☐ Yes

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

Activities of Daily Living:

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:

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."

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Large muscle movement (sitting, crawling, walking)

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

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

Notable concerns:

Small muscle movement (fingers, hands)

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

Is your child using their arms and hands to reach and grasp? ☐ Not yet ☐ Yes

Do you have concerns? ☐ No ☐ Yes *if yes, please describe:*

Interaction with People and Environment:

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:

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

☐ 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:*

Family History

Please provide relevant details on family health history (such as medical, physical and/or mental health, hearing, vision, learning difficulties, communication):

Other services

Does your 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
Name of Centre:	Contact person/title

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

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

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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 beside all that apply to your consent

Consent to Release	Consent to Obtain	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. The records for your child may also be accessed by Centre staff and 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 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 ☐ Muscle Diseases ☐ Oncology ☐ Bio Chem Disease ☐ Complex Feeding Team ☐ Feeding Swallowing Team	
		Sunnyhill Health Clinic (Please check all that apply)	☐Assessment ☐ Visual Impairment Team ☐Assistive Technology ☐ Positioning and Mobility Team ☐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:

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