Infant Development Program

Supported Child Development

Infant Development Program

South Okanagan and Similkameen Early Childhood Services
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Referral Form

Date of referral:	Referral source: Contact #:	Is this an urgent referral ***(for medical professional use only):*** ☐ Yes ☐ No

Child's full name:	☐ Male ☐ Female	Birth date:

Parent/foster parent/guardian names and contact information. Please include first and last names and put an "*" beside best method for contact (e.g. phone, cell phone, email)

Names:	Relationship to child:	Phone: *(H=home; C=cell)*	Email:	Legal guardian: Yes or No
1.				
2.				
3.				

Child's street address *(including city):*	Child's mailing address, if different than street *(including postal code):*

Primary language(s):	Cultural Background *(optional)*	Translator required: ☐ Yes ☐ No

Please explain reason for referral *(attach any relevant reports):*

Family physician/pediatrician:	Other service providers:
Social worker's name *(if involved with MCFD):*	Phone #:

I,________________________________, legal guardian of the above-named child, consent to this referral and authorize the South Okanagan/Similkameen Early Childhood Services Group (comprised of the Infant Development Programs, Child and Youth Development Centre, Supported Child Development Program and Interior Health's Speech-Language Department) to share information, collaborate and participate as members to screen and initiate an action plan for my child.

Signature of parent/guardian:____Date:____________________

Please note*: Signing this consent is voluntary and you may withdraw your consent at any time. This consent will be in effect for one year from the date of your signature.*

October 2018