



**South Okanagan and Similkameen Early Childhood Services**  
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 Mail: #103-550 Carmi Avenue, Penticton, BC V2A 3G6

**Referral Form**

Date of referral:	Referral source:  Contact #:	Is this an urgent referral <i>(for medical professional use only)</i> : <input type="checkbox"/> Yes <input type="checkbox"/> No		
Child's full name:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Birth date:		
<b>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)</b>				
Names:	Relationship to child:	Phone: (H=home; C=cell)	Email:	Legal guardian: Yes or No
1.				
2.				
3.				
Child's street address <i>(including city)</i> :		Child's mailing address, if different than street <i>(including postal code)</i> :		
Primary language(s):	Cultural Background <i>(optional)</i>	Translator required: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Please explain reason for referral <i>(attach any relevant reports)</i> :				
Family physician/pediatrician:		Other service providers:		
Social worker's name <i>(if involved with MCFD)</i> :		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.