Northwest
Child Development Centre
Working together with families, collaborating with communities, strengthening the region

Regional Office- Smithers: **MAIL**: P.O. Box 995, Smithers, B.C., V0J 2N0 **PHONE**: (250) 847-4122 **FAX:** (778) 648-2032 **TOLL FREE:** 1-855-947-4122
Hazelton Location: **PHONE**: (250) 842-5044

REGIONAL OFFICE

Referral Form

School Age Therapy and CDBC - School Entry to 19 Years

Child's Name: ____ (M/F)
Surname First Name Middle initial

Date of Birth: ______________________ Age at Referral: ______________________
Day/Month/Year

Parent/Guardian Name: ______________________ ______________________

Primary Caregiver(s): ______________________ Relationship to child: ______________

Mailing Address: ______________________ Town: ______________

Street Address: ______________________ Postal Code: ______________

Home Phone: ______________ Work Phone: ______________ Cell: ______________

Email Address: ______________________

School Aged Therapy **

☐ Occupational Therapy

☐ Physiotherapy

Complex Developmental & Behavioural Conditions Program

☐ Family Key Worker (CDBC Program, Family Support and Education)

Physicians: ______________________ Diagnosis (If Known) ______________________

Describe reasons for referral:

____
____
____
____
____
____
____
____
____

Referred by: ______________________ Date of Referral ______________________

Signature: ______________________ Phone: ______________________

Parent/Guardian Signature: ______________________ Date: ______________________

**SAT Referrals: Parent/Guardian must complete & sign the attached consent form.

INFORMED CONSENT CHECKLIST

Occupational Therapy & Physiotherapy Assessment & Consultation

Name of Student ____

Date of Birth ________________________ School ____

This informed consent checklist for a school-based occupational therapy/physiotherapy services is intended to help ensure that you have been adequately informed about the service before consenting to it.

1. I am the parent or guardian of this student, and am legally able to give consent on behalf of this student	Yes	No
2. I understand that services consist of consultation; assessment; collection of information; documentation of assessment and recommendations; and sharing findings with the child's school team	Yes	No
3. I understand that this process is voluntary, and that I can refuse an assessment or consultation for my child	Yes	No
4. I understand that photographs, audio-taping and/or video-taping may be needed as part of the assessment process and recommendations	Yes	No
5. I understand that school personnel will consult with the therapists and release any pertinent medical or past assessment information as necessary	Yes	No
6. I understand that this consent is valid until this student is discharged from NWCDC, and that I have the right to rescind consent anytime	Yes	No
7. I understand that I have a right to receive assessment findings and documentation of services provided	Yes	No
8. I give permission to release the findings of the assessment/consultation to the school and the school district.	Yes	No
9. I have been informed of the possible multiple uses of the assessment or consultation information by school personnel	Yes	No
10. I have had an opportunity to ask and have answered any questions or concerns I have about the OT/PT services and about my informed consent	Yes	No

I have voluntarily checked all the boxes above as "yes", and I feel comfortable giving my consent for my child to received occupational therapy and/or physiotherapy services.

Signed: ______________________________________ Date: _________________________

For more information about the occupational/physiotherapy assessment or any aspect of the consent form, please contact the School Age Therapists at the Northwest Child Development Centre (250-847-4122).