# Request for Services

The Child Development Centre of Prince George and District
Heart · Hope · A helping hand

Child Development Centre
of Prince George and District
1687 Strathcona Avenue, Prince George, BC V2L 4E7
Phone: (250) 563-7168 Fax: (250) 563-8039

northern health
the northern way of caring

Speech & Language Clinic
1444 Edmonton Street, Prince George, BC V2M 6W5
Phone: (250) 645-7710 Fax: (250) 645-7982

☐☐☐

**Child's Name:** _____ **Date of Birth:** _____ **Sex at Birth: M /F /X**
First Name, Last Name Month/Day/Year

**PHN#:** _____ **English:** ☒ Other: _____ **Interpreter Needed:** ☐☐ **Gender:** _____
(Personal Health Number) Y / N (if different from sex at birth)

**Identify as Indigenous?** ☐☐ _____ **Ethnicity/Cultural Background:** _____
Y / N

**Legal Guardian:** _____ (_____) **Phone:** _____ _____ _____
First Name, Last Name (Relationship) home cell work

**Address:** _____ _____ _____ _____
Address City Province Postal Code

**Email:** _____

**Legal Guardian:** _____ (_____) **Phone:** _____ _____ _____
First Name, Last Name (Relationship) home cell work

**Address:** _____ _____ _____ _____
Address (if different than the above) City Province Postal Code

**Other:** _____ (_____) **Phone:** _____ _____ _____
First Name, Last Name (Relationship) home cell work

**Address:** _____ _____ _____ _____
Address (if different than above) City Province Postal Code

**Family Physician:** _____ **Paediatrician/Specialists:** _____

**Childcare Program:** _____ **Days/Times Attending:** _____

**Date Referred:** _____ **Referred By:** _____ _____ _____
Agency Phone

→Legal Guardian has given informed consent for this referral: Y☐ N ☐
→Legal Guardian is aware speech and language services are integrated between the CDC and Northern Health: Y☐ N ☐
→Legal Guardian is aware CDC services are integrated with Aboriginal Supported Child Development, and the School District: Y☐ N ☐

**Reason for Referral / History** *(Please include specific concerns, and all relevant medical history including diagnosis, extended hospital visits, communicable diseases, medical alerts, allergies, preferred pronouns)*

****Please send all relevant medical reports to Child Development Centre/Northern Health**

| Please **check all** services that you are requesting: | Physiotherapy ☐ | Occupational Therapy ☐ | Speech Therapy ☐ | SCD ☐ | Family Services ☐ |
|---|---|---|---|---|---|

**Office use only:** ☐ Consents faxed _____ ☐ Request for Services Spreadsheet ☐ Tracking Spreadsheet (therapy only)
☐Phone for Therapy ☐ SCD Letter _____ ☐ Therapy Waitlist Letter _____

**Child Development Centre**
of Prince George and District

# Consent for Service

**Child's Name:**_____ **Date of Birth:** _____

**As the legal guardian of the above-named child I understand and agree to the following:**

- I consent for my child to receive services from the Child Development Centre (CDC). This may include Occupational Therapy, Speech-Language Pathology, Physiotherapy, Supported Child Development, Family Services, and other related support services.
- Services may be offered in-person, at various locations, and/or virtually through video conferencing. By accepting any invitations for virtual services, I am consenting to receiving that virtual support.
- The CDC maintains records relating to the services we provide. Information on your child/family is kept confidential and is protected under the Personal Information Protection Act. We will release this information only in the following circumstances: with your informed consent, as may be contractually required (see following bullet), and/or as legally required.
- The Child Development Centre is contracted by the Ministry of Children and Family Development (MCFD) to provide Supported Child Development, Family Services, and Therapy programming. The related charts that we maintain while providing these services belong to the Ministry. The Ministry may request access to this information including but not limited to the following purposes: audits of services, investigations, or if the Ministry terminates our contract.
- The CDC and the Northern Health Authority's Speech and Language Clinic utilize a common electronic charting system and we provide integrated Speech-Language Pathology services.
- The CDC is a training facility for students in many fields. While receiving services at the CDC, your child may be observed, assessed and/or treated by a student under the supervision of a CDC employee.
- The CDC may charge you for some additional materials and equipment that your child may benefit from. However, this will be provided only with your informed agreement to the associated costs.

The CDC is a registered charity. You have the option of becoming a member of the Child Development Centre's society free of charge for as long as your child receives services from us. Members can participate in the society's general meetings, helping guide our programming. Members may also receive occasional updates regarding our services.

***If you wish to become a member, please initial here*: _____**

**A copy of the Risk and Limitations of Virtual Services can be reviewed online or upon request.**

I_____ understand that this consent is valid for the duration of my child's service and that I can cancel this consent at any time in writing to the Child Development Centre.
Print Name

_____ _____
Signature of legal guardian Signature of witness

Date: _____

**Office use only:** ☐ **Student** ☐ **Consent** ☐ **Membership** ☐ **Virtual Services**

# CHILD DEVELOPMENT CENTRE

of Prince George and District

1687 Strathcona Avenue, Prince George, BC V2L 4E7

Ph: (250) 563-7168
Fx: (250) 563-8039

Email: enquiries@cdcpg.org
Website: www.cdcpg.org


## CONSENT TO OBTAIN / RELEASE INFORMATION

**NAME OF CHILD:** _____ **DATE OF BIRTH:** _____

To provide safe and effective services for your child, it is helpful to both receive and share information about their history, diagnosis, strengths, challenges and progress with other professionals involved in their care. All information is treated with strict confidentiality. This authorization will be valid for a **two-year period**; however, you may withdraw or change it at any time by notifying us in writing.

| **Permission to obtain/ release information (*please initial*)** | **Professional or Agency** | **Name / Phone / Special Instructions** (Information may be shared with initialled agency unless specified.) |
|---|---|---|
| | **Family physician** | |
| | **Specialists** *(includes paediatrician, surgeon, psychiatrist, etc.)* | |
| | **MCFD** *(includes At Home Program)* | |
| | **School District/School** *(private/public)* | |
| | **NFC (ASCD, SLP, OT, etc.)** | |
| | **Outreach Agencies** *(RVCS, MCS, band office, nursing stations, etc.)* | |
| | **AIFDP/IDP** | |
| | **NH** *(UHNBC, SLP, NHAN, audiology, etc.)* | |
| | **Child Care Programs** (*preschool, daycare, afterschool care etc.)* | |
| | **BC Children's Hospital /C & W Hospital** | |
| | **Sunny Hill Health Centre** | |
| | **Other Caregivers** *(foster parents, family, etc.)* | |
| | **Other** *(private therapy, BI, agencies, CDCs etc.)* | |

| Print name of parent/legal guardian | Signature | Date |
|---|---|---|
| Print name of witness | Signature | Date |

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# INTAKE FORM

**Date:** **Information Provided by:**

**Child's Name:** **Date of Birth:**

**Gender Identity/Expression: M / F / Other** **Preferred Pronouns:**

**Father involved? Y☐ N☐** _____ _____
First Name Last Name

**Mother involved? Y☐ N☐** _____ _____
First Name Last Name

**Languages spoken at home:**

**Siblings Names/Birthdates:**

**Daycare/Preschool Name:**

**Do you identify your child as Indigenous? Y☐ N☐ Ethnicity/Cultural Background:**

**Are there any cultural or spiritual beliefs or family values that you would like us to know about in order to provide better services to you and your child?**

**Section I**

1. Please describe your child's strengths:

2. What concerns would you like the CDC to address? (please check all that apply)

   Language/Communication ☐ Behavior ☐ Infant head shape/neck position ☐

   Movement milestones (sitting, crawling, walking, falling/tripping, balance, etc) ☐

   Hand skills (reaching, grasping toys, drawing, cutting, puzzles) ☐

   Daily living skills (feeding, dressing, sleeping, toileting) ☐

   Social skills ☐ Sensory concerns ☐ Parenting Skills/Workshop ☐

   Other:

3. Have you already received any services for your child? Y ☐ N ☐ If yes, which:_____

Please see next page →

**Section II – Birth and Medical History**

4. Was your child born at full term (37 weeks or more)? Y☐ N☐ How many weeks? ___
   Birth weight:_____ Cesarean? Y☐ N☐ (Elective or Emergency)
5. Was there any exposure to drugs, alcohol, tobacco, or prescription medications during the pregnancy? If so, please list:

6. Were there any problems during the pregnancy? If so, please describe:

7. Was your child in intensive care or did s/he have an extended stay in hospital? Y☐N☐
8. Does your child/infant have difficulty with feeding, weight gain or reflux? Y☐ N☐
9. Did your child/infant pass their newborn hearing screen Y☐ N☐ N/A ☐
10. Approximately when did your child achieve the following milestones (in months)?
    Sit up: Crawl: Walk: First words (other than mom and dad):

Other Health concerns of your child:

☐ Vision ☐ Hearing ☐ Nutrition ☐ Cardiac ☐ Respiratory
☐ Other:

11. Has your child been given a diagnosis? Y ☐ N ☐ Please describe