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:

MCFD Referral 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 ☐ Assigned gender at birth:	CLIENT CODE: f**or office use:**
First Nations/Aboriginal Ancestry: ☐ Yes ☐ No	Metis: ☐ Yes ☐ No	
Referring Social Worker:	Phone number:	
Is referring Social Worker Guardian of this child? ☐ Yes ☐ No If No, name of Guardian:	Relationship to the child: ☐ Mother ☐ Father ☐ Other:_____	
Address of Guardian:	City:	Postal Code:
Email:	Phone number of Guardian (if different than above):	
Other Social Worker involved:	Phone number:	
Are there any court orders in place or pending? ☐ Yes ☐ No		

Service requested

☐ Physical Therapy ☐ Inclusive Childcare Program*
☐ Occupational Therapy ☐ Infant Development Program
☐ Speech and Language Pathology

While Starbright will determine appropriate services, your input will be of significant help.

*The Inclusive Childcare Program (ICP) department provides consultation services and potentially extra staffing assistance to ensure inclusive practices for children who need extra support to be successful in daycares and preschools.

Guardian Priorities – Reason for referral

What are your primary developmental concerns for this child?

What are your vision and priorities for this child?

Starbright approval
for office use:

Additional Information	
Emergency Contact: ☐ MCFD ☐ Foster Parent(s) ☐ Mother ☐ Father ☐ Other:_____	
Why is MCFD involved?	
Other medical professionals and/or community services involved:	Phone number:
Daycare/Preschool (if applicable):	Phone number:

Names of Parents (if not Guardians)	
Mother: Involved? ☐ Yes ☐ No Include in intake and appointments? ☐ Yes ☐ No	**Father:** Involved? ☐ Yes ☐ No Include in intake and appointments? ☐ Yes ☐ No
If yes, who is responsible for notifying parent regarding visits?	***If yes***, who is responsible for notifying parent regarding visits?
Are there any booking concerns or instructions? ☐ Yes ☐ No *If yes, please explain:*	Are there any booking concerns or instructions? ☐ Yes ☐ No *If yes, please explain:*
Are there any safety concerns? ☐ Yes ☐ No *If yes, please explain:*	Are there any safety concerns? ☐ Yes ☐ No *If yes, please explain:*
Access or visitation information? ☐ Yes ☐ No *If yes, please explain:*	Access or visitation information? ☐ Yes ☐ No *If yes, please explain:*

Name of Foster Parents	
Names:	
Address:	City:
Postal code:	Phone number:

CLIENT CODE: For office use:

Birth Information and Medical History

Pregnancy and birth description:

☐ Healthy, with no complications ☐ Complications *(please provide medical and health details):*

Delivery: ☐ Vaginal ☐ Caesarean Born at _____ weeks

Birth weight *(please indicate pounds or kilograms):* _____

Was there any known fetal exposure to: Alcohol: ☐ No ☐ Yes

Was there any known fetal exposure to prescription drugs: ☐ No ☐ Yes *(please provide details):*

Was there any known fetal exposure to non-prescription drugs: ☐ No ☐ Yes *(please provide details):*

Medical history:

Does the child use medication? ☐ No ☐ Yes (please specify) _____

Has the child been seen by a specialist? ☐ No ☐ Yes _____

Does the child have a diagnosis? ☐ No ☐ Yes _____

Has the child been hospitalized at any time? ☐ No ☐ Yes _____

Does the child have any allergies? ☐ No ☐ Yes _____

Additional concerns:

PLEASE ATTACH MEDICAL REPORTS IF AVAILABLE

Other services

Does the child receive other treatments for your concerns (e.g. private speech, private physiotherapy, naturopathy, massage, chiropractor, acupuncture, ASD services, etc.)?

☐ No ☐ Yes *If yes, please provide details:*

Name of Centre:	Contact person/title

CLIENT CODE: For office use:

CONSENT FOR SERVICE

The Ministry of Children and Families (MCFD) gives consent to Starbright Children's Development Centre to:

1. Provide services for the above-named child currently "In Care" of MCFD,
2. Make the appropriate service referrals within Starbright's realm of services as listed on page 1,
3. Use audio/visual technology (for the purpose of recording therapy, assessment and progress only),
4. Obtain and/or Release information (verbal and/or written) to the persons or agencies on this page as indicated below. *Please check off in the columns below beside all that apply to indicate your consent.*
5. Obtain and/or Release information with the KGH Feeding and Swallowing Team, the Family Connection Centre (FCC), and the SLP Team at Interior Health, if needed, to work collaboratively.

MCFD understands that records regarding the above-named child may be accessed by Starbright staff. Records may also be 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 guardian.

I consent to Starbright to **release** information to the following:	I consent to Starbright to **obtain** information from the following:			
		Ministry of Children and Family Development	Name	
		Family Physician	Name	Phone
		Pediatrician	Name	Phone
		Foster Parent(s)	Name	Phone
		Mother	Name	Phone
		Father	Name	Phone
		Interior Health Authority	Name	
		Kelowna General Hospital	Name	
		Preschool/Daycare	Name	Phone
		Interior Health Children's Assessment Network	Name	
		Other Community Agencies (e.g. BC Children's Hospital, Sunnyhill Health Clinic, BC Early Hearing Program, etc.)	Name	

MCFD understands and agrees that this consent will continue to remain in effect until all services provided to this child by Starbright Children's Development Centre have ended, or until MCFD has changed this consent. MCFD understands they may request to have this Consent Form updated as information changes.

Authorized signature on behalf of MCFD

_____ _____

Name of Social Worker **Date Signed**

CLIENT CODE: For office use: