South Okanagan and Similkameen Early Childhood Services

Phone: 250-492-0295 Fax: 250-492-2164 Email: communityreferrals@osns.org
Mail: 103-550 Carmi Avenue, Penticton, BC V2A 3G6

Referral Form

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

Child's full name:	☐ Male ☐ Female ☐ Other _____	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 and Similkameen Early Childhood Services group (SOSECS) (comprised of BGCO and PFSS Infant Development Programs, OSNS Child and Youth Development Centre, OneSky 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. Additionally, by providing consent, I am consenting for SOSECS to share and obtain information with the listed referral source to support the above-mentioned 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.*