DREAM BIG THERAPY SERVICES LTD.

REFERRAL FORM

Today's Date _____

Child's Full Name _____ Preferred/Nickname _____

Date of Birth _____ Age _____
(day/month/year) Sex M ☐ F ☐

Name of Parent/Guardian:

Parent/Guardian A _____ Parent/Guardian B _____

Address _____ Address _____
_____ _____
_____ _____

Home Phone _____ */ ___ Home

Phone _____
Cell Phone _____ Cell Phone _____
Work Phone _____ Work Phone _____
Occupation _____ Occupation _____
Email _____ Email _____

Preferred Contact Number _____

Name of Family Doctor _____ Pediatrician _____

Specialists or Agencies involved: Sunny Hill, BC Children's Hospital, Speech, Physio, OT
_____
_____
_____

Please attach copies of reports from other agencies if available
Diagnosis: (Medical and/or Educational) _____
Reason for Referral: (be specific) _____
_____
_____

Strengths _____
_____
_____

Source of Payment
Private _____
Third Party Billing (Autism Funding Unit, Variety Club, At Home Program)
_____

1120 10th Ave SW, Salmon Arm
T: 250-833-4925 | F: 250-833-4966 | E: dreambigtherapyservices@gmail.com

PARENT/GUARDIAN CONSENT FOR OCCUPATIONAL THERAPY ASSESSMENT AND TREATMENT

Child's Name _____

Parent/Guardian Name _____

Occupational Therapy assessment is a process by which an Occupational Therapist gathers information about your child's physical, sensory, phychosocial, cognitive, educational and behavioural function. Assessment results guide Occupational Therapy treatment planning and are used as benchmarks from which to measure progress. Occupational Therapy assessment may consist of any or all of the following: interview and/or questionnaire completed by the parent/guardian, school team/educators, physicians, therapists, etc.; observation of your child in daily settings; administration of formal, standardized Occupational Therapy assessments; administration of non-standardized Occupational Therapy assessment procedures.

Occupational Therapy treatment with your child is focused on helping him/her build the skills they need to successfully participate in childhood daily life. The exact form Occupational Therapy treatment with your child will take is dependent on your child's unique set of skills and needs and by the particular goals you, together with the Occupational Therapist identified.

By signing below and authorizing Dream Big Therapy Services to perform Occupational Therapy assessment and/or treatment, I acknowledge that the following topics were discussed with me, and I fully understand the information presented in those discussions

- ➔ The purpose of any Occupational Therapy assessment/treatment procedure
- ➔ The risks that accompany the Occupational Therapy assessment/treatment procedure
- ➔ The consent for an Occupational Therapy assessment/procedure can be withdrawn at any time

Date _____

Parent/Guardian _____

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CONSENT TO SHARE INFORMATION

Information to be shared may include verbal discussions between professionals, reports, assessments, program documents, consultation records and visit records.

I, _____(print name of parent/guardian) give permission to Dream Big Therapy Services to receive and/or send to the following persons or agencies information concerning my child _____
Date of Birth _____

Name of Professional Agency	Date	Parent/Guardian Signature
Family Doctor		
Pediatrician		
Shuswap Children's Association (occupational therapy, physiotherapy, infant development program, supported child development program, FASD key worker program)		
Speed Language Therapist		
Physiotherapist		
BC Children's Hospital		
Sunny Hill Health Center for Children		
Ministry of Children and Family Development		
School District #83		

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