







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

Child's full name: Male	Date of referral:	Referral source: Contact #:					Is this an urgent referral (for medical professional use only): Yes			
Female										
Parent/foster parent/guardian names and contact information. Please include first and last names and put an """ be method for contact (e.g., phone, cell phone, email) Names: Relationship to child: Relationship to child:	Child's full name:				□ Male			Birth date:		
Parent/foster parent/guardian names and contact information. Please include first and last names and put an """ be method for contact (e.g., phone, cell phone, email) Names: Relationship to child: Phone: (H=home; C=cell)					I Fem	ale				
Names: Relationship to child: Relationship to Phone: CHild's mailing address, if different than street (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 #: Applications and providers in this referral and authorize the South Okanagan are Similkameen Early Childhood Services group (SOSECS) (comprised of BGCO and PFSS Infant Development Programs, and Interior Health's Speech-Language Depshare information, collaborate, and participate as members to screen and initiate an action plan for my child. Additional providing consent, I am consenting for SOSECS to share and obtain information with the listed referral source to support mentioned action plan for my child.										
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1. 2. 3. Child's street address (including city): Primary language(s): Cultural Background (optional) Please explain reason for referral (attach any relevant reports): Family physician/pediatrician: Other service providers: Social worker's name (if involved with MCFD): Phone #: Social worker's name (if involved with MCFD): Phone #:	Names:		•		F	Phone:		Email:	Legal	
2. 3. Child's street address (including city): Primary language(s): Cultural Background (optional) 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 are Similkameen Early Childhood Services group (SOSECS) (comprised of BGCO and PFSS Infant Development Programs, OSN Youth Development Centre, OneSky Supported Child Development Program, and Interior Health's Speech-Language Depshare information, collaborate, and participate as members to screen and initiate an action plan for my child. Additional providing consent, I am consenting for SOSECS to share and obtain information with the listed referral source to support mentioned action plan for my child.			child:		((H=home; C=cell)			guardian:	
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Signature of parent/guardian:Date:	Similkameen Early Childhood So Youth Development Centre, On share information, collaborate, providing consent, I am consen	ervices group (SO eSky Supported (and participate a ting for SOSECS to	SECS) (com Child Develors s members	prised opments to screen	of BGCC Progra	and PFSS Infa m, and Interior initiate an action	nt Develor Health's on plan f	opment Programs, C Speech-Language E or my child. Addition	SNS Child and Department) to nally, by	
	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.

April 2025