EARLY INTERVENTION THERAPY SERVICES
4325 Neill Street
Port Alberni, B.C. V9Y 1E5
Phone: 250-723-1117
Fax: 250-723-7349

CONSENT TO RECEIVE SERVICES

I, the undersigned parent/legal guardian of _____

(Date of Birth) dd-mmm-yyyy _____ do hereby authorize:

☐ Physiotherapy ☐ Occupational Therapy

to provide the following service(s) for the above named child: ☐ in-person ☐ telehealth /virtual, or ☐ both in-person and virtual.

These services may include assessment, recommendations and intervention. I understand that:

- assessment can involve parent/legal guardian/caregiver interview, play-based observations and formal standardized measures. I further understand that all results and recommendations will be shared with me.
- any intervention plan will be designed by the therapist, in collaboration with me, to meet the individual needs and strengths of my child and family within the parameters of the service.
- this is an integrated team including Occupational Therapy and Physiotherapy and that all members of the team will have access to my child's electronic file.
- participation in these services is voluntary and I may withdraw from services at any time.
- admission to services will be at the discretion of the therapist. I further understand that discharge from services will take place on the recommendation of the therapist or by my request.
- This consent expires upon discharge from service or if guardianship changes.
- I understand that I must remain on site for the duration of all therapy sessions

I agree to notify the therapist(s) involved if there is a change in family contact information, emergency contact and guardianship status or custody arrangements for my child.

_____
Name of Parent / Legal Guardian (please print)

_____
Signature of Parent / Legal Guardian

_____
Name of Witness /Clinician (please print)

_____
Signature of Witness /Clinician

_____
Relationship to Child

_____
Date (dd-mmm-yyyy)

Consent type (choose one):

provided by email