EXTENDED THERAPY SERVICES
Outreach Therapy
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) _____, do hereby authorize:

☐ Occupational Therapy ☐ Physiotherapy ☐ Early Childhood Mental Health

to provide service(s) for the above named child.

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 only clinically involved 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.

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

_____ _____
Name of Parent / Legal Guardian (please print) Relationship to Child

_____ _____
Signature of Parent / Legal Guardian Date (dd/mm/yyyy)

_____ _____
Name of Witness (please print) Signature of Witness