



Playful Healing Referral Form

To be filled out and submitted to Childhood Connections by referral agency

PART 1: REFERRAL INFORMATION

Referral Agency _____ Date _____
Address _____ Referred By _____
Phone # _____ Email _____

PART 2: PATIENT INFORMATION

First Name _____ Date of Birth _____
Last Name _____ Gender _____
Location of Residence _____

PART 3: CAREGIVER INFORMATION

First Name _____ Relationship to Child _____
Last Name _____ Phone Number _____
Address _____ Email _____
Other Caregiver(s) _____ Relationship to Child _____

PART 4: COMMENTS/REASON FOR REFERRAL

PART 5: TERMS OF AGREEMENT (to be completed by referral agency only)

- The information presented in this referral is true and complete to the best of my knowledge
- I have read and agreed to the privacy policy (see reverse)
- Childhood Connections may contact me or the referral family with regards to therapy services
- I have express verbal/written permission from the child's legal guardian to share this information with Childhood Connections
- I have thoroughly read and understand the guidelines of Playful Healing referral program and agree this applicant meets the guidelines. I believe the family of this child has financial need and this service is essential to the child's well-being. (see reverse)

Signature: _____ Date: _____



Consideration

- First time applicants will receive priority on the waitlist
- Returning applicants will be considered as funding permits
- Unsuccessful applicants will be notified as quickly as possible

Guidelines

- Child must be between the ages of 30 months and 12 years
- Child must be a resident of the central Okanagan
- The child's family must face considerable social or economic barriers
- The funding will go directly towards paying for the therapy sessions
- Only one application per family per calendar year
- Preference is given to first time applicants
- Incomplete applications will be returned
- Child must not be accessing other therapy support services

Parent/Guardian

- The parent/guardian must give full verbal/written consent for the agency to submit an application on their behalf
- The parent/guardian may assist with parts 2-4 of the application

Referral Agency

- Referral agencies with an established partnership with Childhood Connections may submit referrals
- Referrals from other agencies will be considered on a case by case bases
- Referrals partner must not be related to the child

Privacy/confidentiality policy

- Childhood Connections respects your privacy. We never sell, trade or loan your information to any other organization. Information provided in this referral is being collected solely for the purpose of Playful Healing. The information will only be disclosed to Childhood Connections staff and contracted therapists to carry out the responsibilities of their job. Statistics are reported at the regional and provincial level, however, individuals are not personally identified in any way. By completing and submitting this application form you agree to have all collected information stored in our database system.

Other Programs – Please indicate if the referral family is interested in or you think would benefit from any of the additional free services below

- Circle of Security Parenting Course
- Nobody's Perfect Parenting Course
- Monthly activity/craft bags
- Referral to Nourish Families to receive family sized freezer meals