Pamela Hood Szivek, OT
Canadian Children's Therapy
Victoria, BC
(250) 818-2034

CLIENT REGISTRATION FORM

Client _____ Date of Birth _____

Home Address _____

Parent/Guardian Names	Phone	Email
_____	_____	_____
_____	_____	_____

Physician _____

Paediatrician _____

Diagnosis _____ Allergies _____

Referred by _____

Teacher _____ Grade _____

School _____

Other Professionals involved in care of my child _____

MSP Number_____ Name_____

At Home Program #_____

I authorize Pamela Hood Szivek to share protected health information with the physician of record, the referring professional, and other professionals named above for the purpose of coordination of care.

_____ _____

Signature of Legal Guardian Date
