1135 Nelson Street
Nanaimo BC V9S 2K4
Telephone: 250-753-0251
Fax: 250-753-5614
Email :info@nanaimocdc.com
www.nanaimocdc.com

VANCOUVER ISLAND CHILDREN'S ASSESSMENT NETWORK (VICAN)
GENERAL CONSENT FOR ASSESSMENT SERVICES

I, _____, parent/guardian of _____, born on _____, give permission to have him/her receive a multidisciplinary assessment using historical documents, formal, and informal test instruments. The final report may reflect pertinent information obtained from testing, interviews, and reviews of other reports or documents.

I understand my child's diagnosis may be a reportable condition and information will be shared through the Provincial Health Services Authority to British Columbia Vital Statistics.

☐ I have exercised due diligence and have discussed this consent for assessment with the joint guardian (in the case of shared guardianship).

Please select if you would allow the Nanaimo Child Development Centre contact you electronically:
☐ via email _____
☐ via text messaging _____

This consent shall expire _____, or one year from signing.

* _____ _____ * _____
Parent/Guardian Signature Parent/Guardian Signature Date

* _____ * _____
Witness Date

1135 Nelson Street
Nanaimo BC V9S 2K4
Telephone: 250-753-0251
Fax: 250-753-5614
Email :info@nanaimocdc.com
www.nanaimocdc.com

VICAN AUTHORIZATION FOR OBTAINING INFORMATION ONLY

I, _____parent/guardian of the child_____ born on _____ authorize the following agencies to release copies, extracts, or summaries of ASSESSMENTS, REPORTS, HISTORIES and/or INFORMATION prepared by their programs to the Nanaimo Child Development Centre and to the provincial VICAN database, as needed to complete a multi-disciplinary assessment for my child.

Please fill in names of contacts and agencies.

Agency	Contact Name, Address and Fax #
BC Children's Hospital	
Behaviour Consultant	
Birth Records	
Child Care Facility	
Family Physician	
Family Services	
Infant Development Program	
MCFD (Social Worker/ CYSN/ FASD Key Worker	
Medical Specialist	
Nanaimo Child Development Centre	
Occupational Therapist	
Other custodial parent (if not residing with the child)	
Pediatrician	
Psychologist	
Public Health Nurse	
Queen Alexandra Health Centre	
School District	
Speech Language Pathologist	
Sunny Hill Health Centre	
Other	

This consent shall expire _____, or one year from signing.

* _____ _____ * _____

Parent/Guardian Signature Parent/Guardian Signature Date

* _____ * _____

Witness Date