Developmental Pathways

Dedicated to Individuals with Disabilities

Permission for Transdisciplinary Team Discussion

Developmental Pathways uses a team approach to designing developmental strategies to work with the children eligible for Part C services. The teams consist of Early Childhood Special Educators, Occupational Therapists, Physical Therapists, Speech Language Pathologists, and Licensed Clinical Social Workers. By giving your consent, your primary therapist will verbally present information about your child's development, or will videotape your child to present at a team meeting for discussion of interventions to meet the goals on your IFSP. All team members are Developmental Pathways employees or contractors, or are representatives from either Arapahoe Douglas Mental Health or Aurora Mental Health who provide community consultation.
I give permission for my child, ____ to be videotaped/discussed for team intervention planning. I have been fully informed of the intended use of this information. I also understand that the agency/person receiving this information is obligated to maintain it in a confidential manner and that it is to be used only for the purpose I have authorized. I understand that this information will be kept in a database that is password protected and for the exclusive use of the Part C service coordinators, service providers and their supervisors for the purpose of optimizing communication, resources, and supports for my child and family. I understand my consent is effective for one year from the date of signing. I also understand that I may cancel all or any part by notifying Developmental Pathways at any time.

Aurora Mental Health Center and Arapahoe Douglas Mental Health Center are pleased to offer consultation to families and community partners regarding emotional and behavioral aspects of child and family functioning. We will offer guidance and referral to services that may be helpful, both at the Center and through other community resources. For administrative purposes, we will register your child in our information system to document the consultation and to allow us to associate our service today with any additional past or future contacts. As with all such services by the Center, this registration and related documentation will be held in confidence according to the policy of the agency.

Parent/Guardian Name (please print):

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Parent/Guardian Signature:

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Service Coordinator Name:

____

Date: ______________________