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Children's TREATMENT CENTRE OF CHATHAM-KENT
Celebrating Abilities, Developing Potential

School Therapy Services
Principal Referral Form

☐ **Parent/Guardian has consented to this referral**

Date: _____ Preferred Language: ☐ English ☐ French ☐ Other: _____

Client Name: _____ D.O.B.: _____ ☐ Male ☐ Female

Address: _____

Name of Legal Guardian(s): _____Telephone #(s): _____

School Information:

School Name: _____ Grade: _____

Principal: _____ Classroom Teacher: _____

Learning Resource Teacher: _____

Class Placement: ☐ Regular ☐ Special Education ☐ DD/Life Skills ☐ Other: _____

Behaviour Team Involved? ☐ Yes ☐ No

Student Receiving Resource Assistance: ☐ Yes ☐ No

Has an IPRC Been Held? ☐ Yes ☐ No

Psychoeducational Assessment? ☐ Yes ☐ No

Other: _____

Referral Information:

Assessment Requested: Occupational Therapy ☐ Physiotherapy ☐ Speech Therapy ☐

Comments: _____

What is the expected outcome of the referral? _____

Medical/Developmental Conditions: _____

Please identify the forms which have been completed and are included with this referral:

☐ Teacher Checklist (required for Occupational Therapy and Physiotherapy referrals)

☐ School Board Speech Language Pathologist's Referral (required for Speech Therapy referrals)

☐ Other reports to support the need for assessment

Principal Signature: _____ Date: _____

Once completed please print and fax to 519-354-7355.
For more information on referral process, please contact 519-354-0520.