

School Based Rehabilitation Services and Central Auditory Processing Principal Referral Form

Parent/Guardian has consented to this referral

Date: _____ Preferred Language: English French Other: _____

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

Address: _____

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

Email: _____

School Information:

School Name: _____ Grade: _____

Principal: _____ Classroom Teacher: _____

Person to contact for/form further information: _____ Extension: _____

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

Behaviour Team Involved? Yes No Has an IPRC Been Held? Yes No

Student Receiving Resource Assistance: Yes No EA/DSW Support? Yes No

Psychoeducational Assessment? Yes No High Risk Team Yes No

Other: _____

Referral Information:

Assessment Requested: Occupational Therapy Physiotherapy Speech Therapy
 CAP (7 yrs and older and NOT have a diagnosed intellectual disability)

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, Physiotherapy and Central Auditory Processing referrals)
- School Board Speech Language Pathologist's Referral** (required for Speech Therapy referrals)
- APD Questionnaire** (required for Central Auditory Processing referrals)

Learning Resource Teacher: _____ Email: _____

Principal is aware of and consents to above referral(s) to the CTC-CK

Once completed, please send by mail, courier, fax (519-354-7355) or if parental consent obtained, email to mball@ctc-ck.com. For more information on referral process, please contact 519-354-0520.