

**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

Hearing Test Only  Hearing Priority for Psychological Testing  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.