School Based Rehabilitation Services and Central Auditory Processing Principal Referral Form

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

Date:___________________________________ Preferred Language: ☐English ☐ French ☐Other: _____________

Languages spoken at home: ☐English ☐ French ☐Other: ________________________

Is a language interpreter required for caregiver communication? ☐*Yes* ☐ *No*

Client Name:__________________________D.O.B.: _________________________ ☐Male ☐Female ☐Other:_______

Address: ____

Name of Legal Guardian(s):___________________________________Telephone #(s):_____________________________

Email: ____

Medical/Developmental Conditions: ____

School Information:

School Name: ____ Grade: _________

Principal:______________________________________Classroom Teacher: ______________________________________

Learning Resource Teacher: ______________________________________

Person to Contact for Further Information: ___________________________________ Extension: ________

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

Current School Interventions/ Supports:

☐IEP ☐EA/DSW Support ☐IPRC ☐Student Receiving Resource Assistance ☐Assistive Technology

☐Enrichment ☐ABA Specialists ☐Deaf and Hard of Hearing ☐Blind-Low Vision

☐Multi-disciplinary Student Support Team ☐Collaborative Support Team ☐Wellbeing Team ☐ Behaviour Supports

☐ School Board Speech-Language Team Date of last report: ______________________ Report Attached: ☐ Yes ☐ No

☐Psycho Educational Assessment Completed: Date: ___________________________(**required** if available before referral)

☐Other (i.e., LINCK): ____

Assessment Requested:

☐Occupational Therapy ☐Physiotherapy ☐Speech Therapy ☐Audio Only

☐Audio Priority for Psychological Testing ☐CAP (7 yrs and older and NOT have a diagnosed intellectual disability)

Comments: ____

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What is the expected outcome of the referral? ____

____

Client Name: ______________________ D.O.B.: ______________________

The school is required to be actively involved in supporting the student while they are in the SBRS program. Therapists will ` provide recommendations for the school team to implement. Please check off who will be the most responsible individual/primary school contact for the therapist and provide their name and email address:

☐ Classroom Teacher: ______________________ ☐ Resource Teacher: ______________________

☐ Principal: ______________________ ☐ Other: ______________________

SERVICE HISTORY:	
Has the student previously received SBRS OT? ☐ Yes ☐ No	Year of Discharge: ____________
Has the student previously received SBRS PT? ☐ Yes ☐ No	Year of Discharge: ____________
Has the student previously received SBRS SLP? ☐ Yes ☐ No	Year of Discharge: ____________
Has the school been using the strategies developed by the therapist and are they still working? I.e., P4C strategies, universal recommendations, previous caseload client specific recommendations ☐ Yes ☐ No	
Have you connected with parents and previous teachers to review interventions? ☐ Yes ☐ No	
What has changed? Describe in detail. ______________________	

PLEASE IDENTIFY THE COMPLETED FORMS/SUPPLEMENTARY INFORMATION INCLUDED WITH THIS REFERRAL:
☐ Teacher Checklist (**required** for Occupational Therapy and Physiotherapy referrals)
☐ Sample of Written Output **OR** Drawing/Colouring if not yet printing (**required** for OT fine motor & Assistive Technology referrals)
☐ Speech Language Pathology Referral Form
☐ School Board Speech Language Pathology Report (if available)
☐ Psycho Educational Assessment Report (**required** if available before referral)
☐ Other reports to support the need for assessment
☐ Applicable Individual Education Plan Goals
☐ APD Questionnaire (required for Central Auditory Processing referrals)
☐ Safety plan (if available)

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 cbottrill@ctc-ck.com. For more information on referral process, please contact 519-354-0520.