Children's TREATMENT CENTRE OF CHATHAM-KENT

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 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:

Check what grade the student is presently enrolled in:

Grade: ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☐11 ☐12

(please note that JK/SK referrals are not accepted on this form, encourage parents of JK/SK students to phone the Centre and complete a self-referral)

School Name: ____

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 ☐Safety Plan in Place

☐Psycho Educational Assessment Completed: Date: _______________________________

☐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: ____

355 Lark Street Chatham Ontario N7L 5B2 www.ctc-ck.com
Telephone: 519-354-0520 Fax: 519-354-7355 Toll Free #: 1-833-241-0628

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

What is the expected outcome of the referral? ______________________

____

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)
- ☐ Other reports to support the need for assessment
- ☐ 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

Please Note: Consistent student attendance is needed for success to occur in the therapy programming we provide.

Once completed, please send by mail, courier, fax (519-354-7355) or if parental consent obtained, email cbottrill@ctc-ck.com. For more information on referral process, please contact 519-354-0520. Method of sending referrals is per direction from your school board.

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