School Based Rehabilitation Services and Central Auditory Processing Principal Referral Form

Children's TREATMENT CENTRE OF CHATHAM-KENT

Clear Form

REFERRAL INFORMATION:

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

Consent: Mandatory

☐ Parent/Guardian has agreed to the school making this referral and the sharing of all attached documentation with the Children's Treatment Centre of Chatham-Kent

Consent obtained by (school staff name):	**Date:**

STUDENT INFORMATION:

Name:	Date of Birth: (mm/dd/yyyy)
Address:	Sex at Birth: ☐ Male ☐ Female
Postal Code:	Preferred Pronouns:
Child lives with: ☐ Parent ☐ Foster Family ☐ Kinship Care ☐ Family Member ☐ Other:	
Language(s) Spoken at home:	Interpreter Required ☐ Yes ☐ No
Does the family wish to identify itself or this student as: ☐ First Nation ☐ Metis ☐ Inuit ☐ Other:	
Confirmed Medical/Developmental Conditions:	

CONTACT INFORMATION: Information below Must contain Caregiver Names and/or Organization with Legal Custody or Decision-Making Authority

Name:	Name:
Relationship to Student (required): ☐ Mother ☐ Father ☐ Grandparent ☐ Foster/Kin Family ☐ CAS ☐ Other:	Relationship to Student (required): ☐ Mother ☐ Father ☐ Grandparent ☐ Foster/Kin Family ☐ CAS ☐ Other:
Address: ☐ Same as student Other:	Address: ☐ Same as student Other:
Email Address:	Email Address:
Phone Number:	Phone Number:
Is above name the legal guardian? ☐ Yes ☐ No	Is above name the legal guardian? ☐ Yes ☐ No

SCHOOL INFORMATION:

School:	School Board:	Grade:
Class Placement: ☐ Regular ☐ Modified Program ☐ Life Skills Program ☐ Other:		

Principal:	Email: Ext:
Resource Teacher:	Email: Ext:
Classroom Teacher:	Email: Ext:

Current School Interventions/Supports:

☐ Student Receiving Resource Assistance ☐ IEP ☐ IPRC ☐ Assistive Technology ☐ EA/DSW Support
☐ Enrichment Deaf and Hard of Hearing ☐ Blind-Low Vision ☐ Behaviour Supports
☐ Collaborative Support Team ☐ Well-being Team ☐ ABA Specialists
☐ Multi-disciplinary Student Support Team ☐ Safety Plan in Place
☐ Psycho-educational Assessment Complete: Date:
☐ Other (i.e., LINCK):

ADDITIONAL INFORMATION:

Does the student have any preferred hobbies or extracurricular activities that they enjoy (i.e. ex: sports, church groups, music, drama, etc.)?

Revised August 26, 2026

PLEASE IDENTIFY THE COMPLETED FORMS/SUPPLEMENTARY INFORMATION INCLUDED WITH THIS REFERRAL FORM:
☐ 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 and assistive technology referrals) ☐ Speech-Language Pathologist referral form ☐ School Board SLP Report (if available) ☐ APD Questionnaire and CAPD teacher checklist (**required** for CAP referrals) ☐ Other reports to support the need for assessment
☐ Principal is aware of and consents to the above referral(s) to the CTC-CK

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

The SBRS referral package can be submitted to CTC-CK by:
Email: info.forwarding@ctc-ck.com
FAX: 519-354-7355
Mail: 355 Lark St. Chatham, ON N7L 5B2

For more information and/or questions regarding the referral process, please contact us at 519-354-0520 Ext. 0