

School Based Rehabilitation Services and Central Auditory Processing Principal Referral Form

REFERRAL INFORMATION:		CLEAR FORM
Assessment Requested: ☐ Occupational Therapy ☐ Speech Therapy ☐ Physiotherapy ☐ Audio (psych-ed) ☐ CAP (7yrs and older and NOT have a diagnosis of intellectual disability)		
Consent: <u>Mandatory</u>		
☐ 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	
Confirmed Medical/Developmental Conditions:		
CONTACT INFORMATION: Information below <u>Must</u> contain Caregiver Names and/or Organization with Legal Custody or Decision-Making Authority		
Name:	Name:	
Relationship to Student (required): ☐ Mother ☐ Father ☐ Grandparent ☐ Foster/Kinship ☐ CAS ☐ Other:	Relationship to Student (required): ☐ Mother ☐ Father ☐ Grandparent ☐ Foster/Kinship ☐ 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: ☐ Receiving Resources Assistance ☐ IEP ☐ IPRC ☐ Enrichment ☐ Deaf and Hard of Hearing ☐ Blind-Low Vision ☐ Collaborative Support Team ☐ Well-being Team ☐ ABA Specialists ☐ Behaviour Supports ☐ Multi-disciplinary Support Team ☐ Safety Plan in Place ☐ Assistive Technology ☐ EA/DSW Support ☐ Psych-ed Assessment Completed ☐ 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.)?
PLEASE IDENTIFY THE COMPLETED FORMS/SUPPLEMENTARY INFORMATION INCLUDED WITH THIS REFERRAL FORM:
☐ Teacher checklist (<u>required</u> for Occupational Therapy and Physiotherapy referrals) ☐ Sample of written output OR drawing/colouring if not yet printing (<u>required</u> 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 (<u>required</u> 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