School Based Rehabilitation Services and Central Auditory Processing Principal Referral Form

Children's Treatment Centre of Chatham-Kent

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: 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
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/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 (**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

Revised August 18, 2026