

Date Received: _____
Assigned to: _____

FOR
OFFICE
USE ONLY



Referral Form

9/16/2009

**THIS FORM MUST BE COMPLETED IN ITS ENTIRETY.
INCOMPLETE FORMS WILL BE RETURNED.**

Please check (✓) box(s) for service(s) requested:

- | | |
|---|--|
| <input type="checkbox"/> Educational Psychology | <input type="checkbox"/> Speech-Language Pathology |
| <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Physiotherapy |

REFERRAL DATE:	SCHOOL:
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Student Information:		
Student's Name:		Birth Date (dd/mm/yy):
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Age:	Grade:
Parent / Caregiver:		Relationship:
Home Ph:	Work Ph:	Cell Ph:
Parent / Caregiver:		Relationship:
Home Ph:	Work Ph:	Cell Ph:
Address:		Postal Code:
With whom does the student live?		Siblings in school (list names/school):
Current Diagnosis:		
Is the student currently a Designated Disabled Student? Diversity / Level 1 / Level 2 / No (circle one)		
Criteria for Designation:		
Mobility/ambulation (incl. equipment if using):		
List current medications (name / dosage / frequency):		
List health concerns (e.g. allergies, etc):		
Applicable family information:		
Additional comments:		

School-Based Team:	
School:	Principal:
School Ph:	School Fax:
Home Room Teacher:	Resource Teacher:
Educational Assistant(s):	Additional Team Member(s):

School-based Support Services:	
Educational Assistant:	
Early Reading Intervention (ERI):	
Handwriting without Tears:	
Resource / Special Ed:	
Wellness Coordinator:	

Reason for Referral	Type of Learning Support Services Requested:			
	Educational Psychology	Speech-Language Pathology	Occupational Therapy	Physio Therapy
Follow-up to Kindergarten Screening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Counseling	<input type="checkbox"/>			
Student Observation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Program Consultation/Recommendations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Assessment for Programming Purposes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Assessment for Equipment Needs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Assessment for Auditory Processing	<input type="checkbox"/>	<input type="checkbox"/>		
Assessment for Mobility/ambulation				<input type="checkbox"/>
Assessment for physical limitation				<input type="checkbox"/>
Other: (Explain):				

What specific question(s) do you want answered as a result of this referral?			
Educational Psychology:	Speech-Language Pathology:	Occupational Therapy:	Physiotherapy:

Previous Assessments:		
Name of Assessment:	Date:	Results:

Areas of Concern:		
Social Behaviour	Communication	Academic Behaviour
<input type="checkbox"/> Social skills <input type="checkbox"/> Frustration / Tolerance <input type="checkbox"/> Accepting responsibility <input type="checkbox"/> Accepted by peers <input type="checkbox"/> Appears hyperactive <input type="checkbox"/> Teases / Bullies peers <input type="checkbox"/> Has few friends <input type="checkbox"/> Demands attention <input type="checkbox"/> Acts impulsive <input type="checkbox"/> Distractible	<input type="checkbox"/> Oral expression <input type="checkbox"/> Voice quality <input type="checkbox"/> Distorts speech sounds <input type="checkbox"/> Omits speech sounds <input type="checkbox"/> Stuttering / Fluency <input type="checkbox"/> Following directions <input type="checkbox"/> Listening comprehension <input type="checkbox"/> Hearing <input type="checkbox"/> Difficulty expressing self <input type="checkbox"/> Unable to sequence information <input type="checkbox"/> Phonological awareness <input type="checkbox"/> Difficulty with word-finding	<input type="checkbox"/> Problems decoding language <input type="checkbox"/> Excessively slow copying skills <input type="checkbox"/> Inattention during instruction <input type="checkbox"/> Difficulty initiating work <input type="checkbox"/> Difficulty completing assignments <input type="checkbox"/> Limited vocabulary skills <input type="checkbox"/> Difficulty with reading comprehension <input type="checkbox"/> Spelling problems <input type="checkbox"/> Difficulty with recognition or discrimination between sounds
Emotional Behaviour	Memory	Physical
<input type="checkbox"/> Aggression <input type="checkbox"/> Immature behaviour (low tolerance for frustration) <input type="checkbox"/> Withdrawn <input type="checkbox"/> Appears unhappy / depressed	<input type="checkbox"/> Poor short-term memory <input type="checkbox"/> Requires frequent repetition <input type="checkbox"/> Difficulty with long-term memory	<input type="checkbox"/> Tilts head toward direction of sound source <input type="checkbox"/> Demonstrates physical symptoms under stress (e.g. stomach aches) <input type="checkbox"/> Crusted, red, swollen eyelids, watery eyes, rubbing eyes <input type="checkbox"/> Mobility <input type="checkbox"/> Sensory processing <input type="checkbox"/> Messy paper / pencil tasks <input type="checkbox"/> Eye-hand coordination <input type="checkbox"/> Fine motor coordination <input type="checkbox"/> Gross motor coordination
Other (please list):		

What equipment / adaptations / modifications have been successful in helping this student?

Outside Agency Involvement (KCC, Child and Youth Services, Ministry of Social Services, etc):			
Agency:	Professional:	Date:	Type of Involvement:

Current School Performance:	
Skills	Comments:
Written Expression	
Oral Expression	
Listening Comprehension	
Reading Skills	
Math Skills	
Social Skills	
Behavioral/Emotional Skills	
Fine Motor Skills	
Gross Motor Skills	
Mobility	
Strengths and Interests:	

Signatures (where applicable):	
Classroom Teacher:	Principal:
Special Education Resource Teacher:	Superintendent / Coordinator: