Quinte Children's Treatment Centre
Quinte Health Care
Belleville General Hospital
265 Dundas Street East
Belleville, ON K8N 5A9

Telephone: **(613) 969-7400 x2784**
Fax: **(613) 961-2517**

SBRS REFERRAL REQUEST

How to refer:

- Please complete all fields and be sure to download/save the completed form to your computer/device to avoid submitting a blank form. If a blank or incomplete form is submitted using the secure upload method, there is no way to identify and notify the sender.
- Secure upload using Sync.com (please see instructions on our website *www.quintectc.com*) ***or*** Fax to 613-968-9154

Questions? Call: 613-969-7400 ext. 2247

SERVICES REQUESTED

☐ *Occupational Therapy ☐ *Physiotherapy ☐ *Speech Therapy

☐ Urgent equipment needs required for school entry (i.e. ramp, grab bars, mobility device)

☐ Request for service in French – if attending French school

**Supporting documentation must accompany referral*

YOUTH/CHILD INFORMATION

Last Name: First Name:

Date of Birth: *(dd/mmm/yy)* / / Gender: (select gender) Phone: - -

Address: City: Prov: Postal Code:

PARENT/GUARDIAN INFORMATION

Primary Contact Last Name: First Name:

Relationship to Child: (select relationship) *(if Other or Agency, please specify)*

(check all that apply) ☐ Legal Guardian ☐ Custody ☐ Access to Health Record ☐ Lives with Child

Home Phone: - - Cell: - - email:

Address: ☐ Same as child's above-listed address ☐ Other than child's above-listed address *(if Other, provide below)*

Address: City: Prov: Postal Code:

Second Contact Last Name: First Name:

Relationship to Child: (select relationship) *(if Other or Agency, please specify)*

(check all that apply) ☐ Legal Guardian ☐ Custody ☐ Access to Health Record ☐ Lives with Child

Home Phone: - - Cell: - - email:

Address: ☐ Same as child's above-listed address ☐ Other than child's above-listed address *(if Other, provide below)*

Address: City: Prov: Postal Code:

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CUSTODY ARRANGEMENTS

Custody Arrangements: ☐ No formal agreement ☐ Formal Agreement in Place ☐ Parents live together with child

(briefly explain)

All legal guardians are aware of and have consented to this referral: (choose Yes or No) **(if no, referral cannot be processed)**

ADDITIONAL INFORMATION

Language(s) Spoken/Understood By Child: Interpreter required: (choose Yes or No)

Diagnosis(es), *if any*:

Other services involved (eg. CAS):

Primary Physician: Phone Number: - -

Other Physician: Phone Number: - -

SCHOOL INFORMATION

Does the student have an Individualized Education Plan (IEP)? (choose Yes or No) *(if yes, please attach)*

Does the student have an Identification, Placement and Review Committee (IPRC) designation? (choose Yes or No)

(if yes, briefly identify exceptionality)

Is there a Safety Plan for this student? (choose Yes or No)

(if yes, briefly describe)

Has the school completed any other assessments or testing with this student? (choose Yes or No)

(if yes, briefly provide details)

School Board: ☐ ALCDSB ☐ HPEDSB ☐ CEPEO ☐ CECCE ☐ PDSB (Provincial & Demonstration

School: City:

Learning Support Teacher: LST's email:

Classroom Teacher: Grade: (select grade)

School Principal: Phone: - -

REFERRAL SOURCE

Referred by: Date: *(dd / mmm / yy)* / /

Signature: *(type name to sign form electronically)*