Quinte Children's Treatment Centre QHC

265 Dundas Street E.
Belleville ON K8N 5A9
Tel: (613) 969-7400 ext. 2784
Fax: (613) 961-2517

School Based Rehabilitation Services

Enabling Participation, Socialization and Learning

Referral Request Form

Services Requested: *(please check all that apply)*

- ☐ Occupational Therapy
- ☐ Physiotherapy
- ☐ Speech Therapy

For any questions, please contact the number above

Referrals will not be processed without the following supporting documentation and reason for referral:
SLP Referral Report and/or **OT/PT Additional Information Form**

A. Child/Youth Demographics:

Last Name:			Date of Birth: Day Month Year
First Name:			Gender:
Primary address:		City:	Postal Code:

1st **Parent and/or Guardian**'s Name:				Is this the primary contact? ☐ Yes	
Legal Guardian: ☐ Yes ☐ No		Living with Child: ☐ Yes ☐ No		Relationship to Child:	
Address:		City:		Postal Code:	
Tel: (H)	(C)	(W)		X	Preferred: (select)

2nd **Parent and/or Guardian**'s Name:				Is this the primary contact? ☐ Yes	
Legal Guardian: ☐ Yes ☐ No		Living with Child: ☐ Yes ☐ No		Relationship to Child:	
Address:		City:		Postal Code:	
Tel: (H)	(C)	(W)		X	Preferred: (select)

Custody Arrangements: ☐ Joint Custody ☐ Sole Custody ☐ No agreement ☐ Formal Agreement ☐ Family and Children Services

Comments/Details:

B. Additional Information:

Language(s) Spoken/Understood by child:		Is an interpreter required?: ☐ Yes ☐ No	
Diagnosis (*if applicable*):	Primary physician:		Tel:
Other physician:	Tel:	Other physician:	Tel:
Allergies (if any):		Other:	

C. Referral Source Information: (*Reason for referral must be included in supporting documentation*)

☐ School ☐ Parent ☐ Other (please specify)

Name:	Contact Info:

D. School Information

School Board: (*select*)	☐ ALCDSB	☐ HPEDSB	☐ CEPEO	☐ CECCE	☐ Provincial
School:				City:	
Resource Teacher:			Classroom Teacher:		
School Principal/Designate:				Tel:	

Referred by: *(print or type name including title)*	**Signature:** (*sign printed form*)	**Date:**

Quinte Children's Treatment Centre QHC

265 Dundas Street E.
Belleville ON K8N 5A9
Tel: (613) 969-7400 ext. 2784
Fax: (613) 961-2517

School Based Rehabilitation Services
Enabling Participation, Socialization and Learning

Consent for Referral and Information Sharing

To be completed by the Parent/Legal Guardian or Client:

Please print or type your full name: _____

Please print or type the full name of the student: _____

Please indicate your relationship to the student: _____

Please select ONE:

☐ I am the legal guardian of the above named child. **OR** ☐ I am the client and am at least 16 years of age.

Consent for Services:

By signing this, you are consenting to the start of School-Based Rehabilitation Services. This will authorize Quinte Children's Treatment Centre (QCTC) to collect, use and disclose relevant information regarding my child for the purpose of determination of eligibility, prioritization, service planning, treatment/care, and program evaluation of the School-Based Rehabilitation Services.

Consent for Sharing of Information:

Services work best when there is good communication among everyone involved with you and your child. I do hereby authorize the exchange of information to and from:

Yes	No	
☐	☐	QCTC with Quinte & District Rehabilitation (Quinte Rehab is the agency providing therapy in school)
and		
☐	☐	QCTC with School Board

(select School Board)

- ☐ Hastings and Prince Edward District School Board (HPEDSB)
- ☐ Algonquin and Lakeshore Catholic District School Board (ALCDSB)
- ☐ Conseil des écoles publiques de l'Est de l'Ontario (CEPEO)
- ☐ Conseil des écoles catholiques du Centre-Est (CECCE)
- ☐ Provincial School Board (specialized)

and

☐ ☐ Quinte Rehab with School Board

and

☐ ☐ Other (specify) _____

Quinte Children's Treatment Centre is committed to your privacy and is compliant with the Ontario Personal Health Information Protection Act. This authorization is valid for as long as my child is receiving services through the QCTC. This authorization may be withdrawn at any time by submitting a written request to the QCTC at the above address.

Limitation to sharing:

Please indicate below any individual or facility with whom you DO NOT wish QCTC, the School/School Board or Quinte Rehab staff to communicate. Please indicate the relationship to the client. If the request is to not communicate with a biological parent, please provide supporting documentation.

Individual's name _____

Individual's relationship to student _____

Signature: (*sign printed form*)	**Date:**
_____	_____

Quinte Children's Treatment Centre QHC

265 Dundas Street E.
Belleville ON K8N 5A9
Tel: (613) 969-7400 ext. 2784
Fax: (613) 961-2517

School Based Rehabilitation Services

Enabling Participation, Socialization and Learning

OT/PT Additional Information Form

Student's Name:	Date of Birth: Day Year
School Name:	Class/Grade: Month

A. Reason for Referral

Referred By (Name and Position):

B. Safety & Participation

Is there a safety plan? ☐ Yes (If yes, please attach) ☐ No

Is there a safety issue? ☐ Yes (If yes, please describe) ☐ No

Do the referral concerns affect the child/youth's ability to access the curriculum or attend school?

☐ Mildly ☐ Moderately ☐ Unable to access any part of the curriculum/Attend school

C. History & Support

Does the child/youth have an Individualized Education Plan (IEP)?

☐ Yes (If yes, please attach) ☐ No ☐ Unknown

Does the child/youth have an Identification, Placement and Review Committee (IPRC) designation?

☐ Yes (If yes, please attach) ☐ No ☐ Unknown

Does the child/youth have a psychological assessment?

☐ Yes (If yes, please attach) ☐ No ☐ Unknown

Has the child/youth received school based services previously (formerly SHSS)?

☐ Yes ☐ No ☐ Unknown If yes, what strategies have been put into place?

If the child/youth has received OT/PT service before, what has changed?

Has the school been using any strategies to address concerns? ☐ Yes ☐ No

Are they still working? ☐ Yes ☐ No Please elaborate:

Have you connected with parents and previous teachers to review interventions? ☐ Yes ☐ No

Are there strategies identified in the OSR or with the resource teacher? ☐ Yes ☐ No

What (if any) other resources have been accessed? ☐ Behavioural Team ☐ Children's Mental Health

☐ Ontario Autism Program (OAP), ☐ School Board Resources, ☐ Other (specify)

Student's Name:	Date of Birth: Day Year

D. Information for Therapy Referral

Please identify any equipment used by the child for mobility at school:

Areas of Concern:

☐ Gym ☐ Playground ☐ Safety

☐ General Mobility & Accessibility ☐ Equipment Concerns ☐ Other ☐ N/A

Please provide description or examples:

Please check areas of concern: ☐ Fine Motor/Hand Skills ☐ N/A

Please provide description or examples:

☐ Printing/Written Output* ☐ N/A

Please provide description or examples:

*Please indicate support and/or adaptations for printing/handwriting that have been tried:

- ☐ Printing/Cursive Writing Program
- ☐ 1:1 Support
- ☐ Technology/Software Programs
- ☐ Alternative Pencil Grips or Lined Paper
- ☐ Other (Please describe):

☐ Sensory** ☐ N/A

Please provide description or examples:

**What Sensory resources does your school have?

- ☐ Sensory Room
- ☐ Basic Sensory equipment
- ☐ Other (Please describe):

What strategies have you tried?

- ☐ Environmental Adaptations
- ☐ Body Breaks
- ☐ Other (Please describe):

☐ Self-Care (Toileting, Feeding, Dressing) ☐ N/A

Student's Name:	Date of Birth: Day Year

☐ Other

Please provide description or examples:

Please attach supporting documentation.

Form available at www.quintectc.com and is fillable to allow for more detail.