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:	
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:
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:

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:**

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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:**
______________________________	______________________________