Quinte Children's Treatment Centre QHC

265 Dundas Street East
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

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

Services Requested:
(please select one or more)

- ☐ Occupational Therapy
- ☐ Physiotherapy
- ☐ Speech Therapy

For any questions, please contact the number above

A. Child/Youth Demographics:

Last Name:	First Name:	
Date of Birth: Day Month Year	Gender: (please select gender)	
Address:	City:	Postal Code:
Parent/Guardian Name:		
Legal Guardian: ☐ Yes ☐ No	Living with Child: ☐ Yes ☐ No	Relationship:
Address: *(if different than child's)*	City:	Postal Code:
Check preferred #: ☐ Home:	☐ Cell:	☐ Work: Ext
Parent/Guardian Name:		
Legal Guardian: ☐ Yes ☐ No	Living with Child: ☐ Yes ☐ No	Relationship:
Address: *(if different than child's)*	City:	Postal Code:
Check preferred #: ☐ Home:	☐ Cell:	☐ Work: Ext

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

Comments/Details:

B. Additional Information:

Language(s) Spoken:	Interpreter Required: ☐ Yes ☐ No	
Diagnosis (*if any*):	Physician(s):	Phone:
Allergies (if any):	Other:	

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

☐ School ☐ Parent ☐ Other (please specify)

Name:	Contact #:

D. School Information

School Board:	☐ ALCDSB	☐ HPEDSB	☐ CEPEO	☐ CECCE	☐ Provincial
School:				City:	
Resource Teacher:			Classroom Teacher:		
School Principal/Designate:		Phone:		Fax:	

Referred by: *(print name including title)*	**Signature:**	**Date:**

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Consent Form

Consent for Referral and Information Sharing

I, _____ do hereby give consent for the
(Parent/Legal Guardian)

_____ District School Board to refer my child,
(name of school board)

_____, to the Quinte Children's Treatment Centre (QCTC)
(name of child)

for the purpose of determining my child's therapy needs at school.

I understand, if accepted for therapy service, Quinte and District Rehabilitation (Quinte Rehab) will be providing therapy to my child in school on behalf of the QCTC.

I hereby give my permission to the QCTC, the school board listed above and Quinte Rehab for the exchange of verbal and written information that is relevant to the care of my child while a client of the QCTC. Information will only be exchanged for the purpose of coordinating the care/treatment of my child between agencies.

The QCTC is committed to your privacy and is compliant with the Ontario Personal Health Information Protection Act. You may withdraw your consent at any time with a written request to QCTC.

Signature of Parent/Guardian:	**Date:**
_____	_____
Witness:	**Expiry Date:**
_____	_____

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SLP Referral Report

Referrals for speech and language services are to come from an SLP with input from parent and teacher/school.

Student's Name: **Date of birth:** 1 1 1

School: **Name of SLP:**

Reason for referral: *(check all that apply)*

- ☐ **Articulation:** ☐ Motor Speech ☐ Articulation/Phonological Delay ☐ Moderate ☐ Severe
  - ☐ Cognitive delays ☐ Lateralization ☐ Unstimulable "R"
- ☐ **Voice:** ☐ Post surgical ☐ Severe/Moderate ☐ Mild
- ☐ **Fluency:** ☐ Mild ☐ Moderate ☐ Severe
- ☐ **Resonance:** ☐ Post surgical ☐ Mild/Moderate/Severe
- ☐ **Feeding/Swallowing**

Has the child seen by an ENT or been referred to an ENT? ☐ Yes ☐ No ☐ Unknown

If "Yes", where/by whom? *(include report from ENT if available)*

PLEASE NOTE: If the referral is for voice or resonance, the child MUST be referred to an ENT.

Has the child had a recent hearing test? ☐ Yes ☐ No ☐ Unknown

Does the child have any known diagnosis? ☐ Yes ☐ No ☐ Unknown

If "Yes," please specify, including known source making the diagnosis.

PLEASE INCLUDE any available reports verifying the diagnosis

***Confounding variables** (i.e. language delay, attention behavioural issues, safety plan?):

ATTACH applicable reports if available

***Will the school board speech and language pathologist remain involved?** ☐ Yes ☐ No

If "Yes," indicate the services to be received and from whom:

Is a CDA involved? ☐ Yes ☐ No If "yes," whom:

Parent goals *(please do not exceed 4 lines of text)*:	**Teacher/school goals** *(please do not exceed 4 lines of text)*:

Print Name: **Agency:**

***Signature:** _____ ***Date:** _____

Last updated 12 Feb 2019