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:**

Last updated 18 Jun 2019

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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:**
______________________________	______________________________

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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:**

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