KidsInclusive EnfantsInclus
Centre for Child & Youth Development
Centre du développement des enfants et des adolescents

Kingston Health Sciences Centre
Centre des sciences de la santé de Kingston

School-Based Services Referral

CONFIDENTIAL

Submit by Mail or Fax to 613-545-3557 Questions? Call 613-544-3400 x 3314 or Toll Free: 1-855-544-3400 ext. 3314

Services Requested: ☐ Occupational Therapy ☐ Physiotherapy ☐ Speech Therapy	**Referrals will not be processed without the following supporting documentation:** Speech Therapy: ☐ SLP Additional Information Form; *AND,* ☐ Most Recent SLP Report ☐ *PSL - Report to be submitted at discharge* Occupational Therapy and/or Physiotherapy ☐ OT/PT Additional Information Form

A. Child / Youth Demographics:

Last Name:	First Name:	
Date of Birth (dd/mmm/yyyy):	Gender:	
Address:	City:	Postal Code:
Primary Contact (Parent/Guardian Name):		
Legal Guardian: Y ☐ N ☐ Living With Child: Y ☐ N ☐	Relationship to Child:	
Address: Same Y ☐ N ☐	City:	Postal Code:
Check Preferred # ☐ Home #:	☐ Cell #:	☐ Work #:
Secondary Contact:		
Legal Guardian: Y ☐ N ☐ Living With Child: Y ☐ N ☐	Relationship to Child:	
Address: Same Y ☐ N ☐	City:	Postal Code:
Check Preferred #: ☐ Home #:	☐ Cell #:	☐ Work #:
Custody Arrangements: ☐ Joint ☐ Sole ☐ No Agreement ☐ Formal Agreement ☐ Family &Children Services ☐ N/A Comments/Details:		

B. Additional Information:

Language(s) Spoken:	Interpreter Required: Y ☐ N ☐	
Physician(s) Name:	Physician(s) Phone:	Allergies (if any):
Pertinent Medical History:	Diagnosis (if any):	

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C. School Information:

School Board: ☐ LDSB ☐ ALCDSB ☐ UCDSB ☐ CEPEO ☐ CECCE ☐ CDSBEO

School:	City:	
Resource Teacher:	Classroom Teacher:	Grade:
School Principal/Designate:	Phone:	Fax:

D. History & Support

Cognitive Skills: ☐ Delayed ☐ Not Assessed ☐ WNL (Within Normal Limits)

Hearing: Concerns: Y ☐ N ☐ Describe:

Recent Hearing Test: Y ☐ N ☐ If Yes, Date of Test:

Language Development: ☐ Delayed ☐ Not Assessed ☐ WNL

Behaviour:

WNL	Y ☐ N ☐	Attention Difficulties	Y ☐ N ☐
Behaviour Concerns	Y ☐ N ☐	Behaviour Plan in Place	Y ☐ N ☐
Safety Concerns	Y ☐ N ☐	Safety Plan in Place	Y ☐ N ☐

School Board Behaviour Specialist Involved Y ☐ N ☐

Testing: Please indicate any specialized testing completed in the past.

☐ Psych Ed. ☐ Neurology ☐ Medical/Pediatrics ☐ ENT
☐ OT ☐ PT ☐ SLP ☐ Other_____

Does the child/youth have an Individualized Education Plan (IEP) Y ☐ N ☐ Unknown ☐

Please summarize accommodations, modifications, and/or areas of exceptionality:

Has the student previously received School-Based Services: OT - Y ☐ N ☐ SLP - Y ☐ N ☐ PT - Y ☐ N ☐

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

☐ School ☐ Parent ☐ Other (Please specify):

Name:	Contact Info:

F. Consent for School Based Services Referral and for Sharing of Information: To be completed by the parent/legal guardian or client (if over 16 years of age). Please note that consent can be withdrawn at any time by notifying KidsInclusive in writing

The reason for referral to the School Based Services Program has been explained to me and I consent to this referral. I understand that my child's personal and personal health information will be shared between KidsInclusive and relevant school board personnel to determine eligibility for the program and to arrange services.

Yes ☐ No ☐

KidsInclusive is required by Ontario's privacy laws to use practices that protect the safety and security of personal health information. KidsInclusive will not share your child's personal health information without your consent except as permitted by law. For questions related to consent, use and disclosure of personal health information please call KidsInclusive at 613 544 3400 ext. 3175 or toll free 1 800 544 3400 ext. 3175

Name of Parent/Legal Guardian/Client (Please Print): _____

Signature: _____

Date (dd/mmm/yyyy): _____

Verbal consent - please confirm the statement above is reviewed with the person providing consent and select YES or NO according to their response.

Verbal consent obtained by: _____

Date (dd/mmm/yyyy): _____