|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **REFERRAL for LEARNING SUPPORT SERVICES**  School District 10 (Arrow Lakes)  Phone: 250-265-3638 Ext. 3320 | | | | | | | | | | | | | | Description: Description: SD10_Logo_RGB_screen | | | | | | | |
|  | | | | | | | | | |  | | | | | | |  | | | | |
| **STUDENT INFORMATION** | | | | | | | | | | | | | | | | | | | | | |
| Student: | | | | | | | | | | DOB: | | | | | | | Date: | | | | |
| Enrolling Teacher: | | | | | | | | | | PEN: | | | | | | | Grade: | | | | |
| Parent(s)/Guardian(s): | | | | | | | | | | School: | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
| **REFERRAL INFORMATION** | | | | | | | | | | | | | | | | | | | | | |
| School Based Team (SBT) Members: | | | | | | | | | | | | | | | | Date: | | | | | |
| Reason: | | | | | | | | | | | | | | | | | | | | | |
| Intervention(s) | | | 1. | | | | | | | | | | | | | Date: | | | | | |
| Already Tried: | | | 2. | | | | | | | | | | | | | Date: | | | | | |
|  | | | 3. | | | | | | | | | | | | | Date: | | | | | |
| Case Manager: | | | | | | | | | | | \*Please attach SBT Meeting Minutes. | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
| **SERVICES REQUESTED** (Check all applicable services required) | | | | | | | | | | | | | | | | | | | | | |
| Elementary Counsellor **\*** | | | | | | | Teacher of the Deaf and Hard of Hearing Services **\*** | | | | | | | | | | | | | | |
| Speech and Language Pathologist **\*** | | | | | | | Teacher of the Visually Impaired Services | | | | | | | | | | | | | | |
| Occupational Therapist \* | | | | | | | Physiotherapist | | | | | | | | | | | | | | |
| School Psychologist **\*** | | | | | | | **\*** Please attach completed additional service specific checklist. | | | | | | | | | | | | | | |
| **Signatures:** | |  | | | |  | |  | | | | |  | |  | | | | |  | |
|  | | Referring Teacher | | | |  | | Learning Resource Teacher | | | | |  | | Principal | | | | |  | |
|  | | | | | | | | | | | | | | | | | | | | | |
| **INFORMED CONSENT** | | | | | | | | | | | **Please Initial: AGREE \_\_\_\_\_ DO NOT AGREE \_\_\_\_\_** | | | | | | | | | | |
| Informed consent is the result of a process of reaching an agreement to work together collaboratively, rather than simply having a consent form signed. In obtaining informed consent, parents and guardians should be provided with as much information as a reasonable or prudent person would want to know before making a decision or consenting to a School District assessment process, procedure, or service. Reasonable steps should be taken to ensure that all the appropriate information is conveyed to the parent or guardian in a manner to ensure that they clearly understand what they are consenting to on behalf of their child. | | | | | | | | | | | | | | | | | | | | | |
| **PARENT CONSENT** | | | | | | | | | | | **Please Initial: AGREE \_\_\_\_\_ DO NOT AGREE \_\_\_\_\_** | | | | | | | | | | |
| I give permission for School Learning Services staff to work with and observe my child in a school setting. Should specific suggestions for home application arise, then I expect to be consulted. I understand that a report may be taken to my child’s school and discussed with the teacher (and other District Staff as appropriate) so that they can consider any recommended program adjustments. I further understand that I will be actively involved in decisions regarding special placements and/or placements. | | | | | | | | | | | | | | | | | | | | | |
| **AUTHORIZATION TO OBTAIN INFORMATION** | | | | | | | | | | | **Please Initial: AGREE \_\_\_\_\_ DO NOT AGREE \_\_\_\_\_** | | | | | | | | | | |
| When a parent gives consent for services they are also giving permission for the specialist to access all relevant documents concerning the referred student and to speak with other School District professionals who have been involved with the student. This consent to access confidential information may be revoked by the parent at any time. When the assessment is completed, the consent will automatically be revoked. The information collected on this form (authority: School Act (section 13 and 97) will be protected under the Freedom of Information and Protection of Privacy Act. The information will be shared for education program purposes and if legally required by section 97 (2) of the School Act, may be provided to health services or other support services. Questions about the collection and use of this information should be directed to the principal of your school. | | | | | | | | | | | | | | | | | | | | | |
| **ACKNOWLEDGEMENT AND CONSENT** | | | | | | | | | | | | | | | | | | | | | |
| I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ acknowledge that I have read and understood the information above. | | | | | | | | | | | | | | | | | | | | | |
| **AGREE**  I (we) have read the information above and consent to have the service(s) indicated performed with my (our) child. | | | | | | | | | | | **DO NOT AGREE**  I (we) have read the information above. I (we) do not consent to have the service(s) indicated performed with my (our) child. | | | | | | | | | | |
|  |  | | |  |  | | | |  | |  |  | | | | | |  |  | |  |
|  | **Signature of Parent or Legal Guardian** | | |  | **Date** | | | |  | |  | **Signature of Parent or Legal Guardian** | | | | | |  | **Date** | |  |
|  | | | | | | | | | | | | | | | | | | | | | |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Description: Description: SD10_Logo_RGB_screen | | | REFERRAL LEARNING SUPPORT SERVICES | | | | | | |
| **OCCUPATIONAL THERAPY REFERRAL QUESTIONNAIRE** | | | | | | | | | |
| Special Education Designation: Yes  No  ; If Yes, which category? | | | | | | | | | |
| Family with Whom Student Resides: | | | | | | | | | |
| Address: | | | | | Postal Code: | | | | |
| Home Phone: | | | | | Work Phone: | | | | |
|  |  | | | | |  | |  | |
| Reason(s) for Referral: | Fine Motor | | | | | Gross Motor | | Self-Regulation | |
| Written Output | Sensory | | | | | Activities of Daily Living | | | |
|  | | | | | | | | | |
| Formal Documentation Required for:  Diagnosis  Designation  IEP goal(s), objectives, strategies  Interpretation of Medical Report (i.e. Mental Health OT, CDBC OT Report, etc.)  Other | | | | | | | | | |
|  | | | | | | | | | |
| This student has also received support from: | | | | | | | | | |
| School District SLP | | School District Psychologist | | | | | School Counsellor | | |
| LA Teacher | | Physiotherapist | | | | | Resource Teacher | | |
| Other:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | |
|  | | | | | | | | | |
|  | | | | | | | | | |
| **Teacher Checklist** | | | | | | | | | |
| Name: | | | | | Date: | | | | |
|  | | | | |  | | | | |
| **Written Output** | | | | | **Self-Care** | | | | |
| Unestablished hand dominance | | | |  | Difficulty with toileting | | | |  |
| Inefficient pencil grip (see resources) | | | |  | Difficulty with clothing | | | |  |
| Delayed pre-printing skills | | | |  | Difficulty eating independently | | | |  |
| Difficulty with letter formation | | | |  | Difficulty chewing and swallowing | | | |  |
| Difficulty in copying from: | | | |  | Difficulty with personal hygiene | | | |  |
| board | | | |  |  | | | |  |
| book | | | |  | **Fine Motor Skills** | | | |  |
| dictation | | | |  | Avoids fine motor activities | | | |  |
| Poor body positioning | | | |  | Trouble with gluing or craft activities | | | |  |
| Rotates paper when writing | | | |  | Trouble with cutting | | | |  |
| Quality of writing is inconsistent | | | |  | Trouble with tracing activities | | | |  |
| Size of letters does not remain constant | | | |  | Difficulty using hands together | | | |  |
| Very slow performance of written work | | | |  | Sometimes gets left and right confused | | | |  |
| Inconsistent work | | | |  | Difficulty with fastenings, containers | | | |  |
|  | | | | | | | | | |
|  | | | | | | | | | |
| **General Academic Performance** | | | | | | | | | |
| **Reading** | | | |  | **Math** | | | |  |
| At grade level | | | |  | At grade level | | | |  |
| Approaching | | | |  | Approaching | | | |  |
| Not yet within | | | |  | Not yet within | | | |  |
|  | | | | | | | | | |
| **Gross Motor** | | | | | | | | | |
| Has difficulty walking in school | | | |  | Has awkward walking pattern | | | |  |
| Becomes tired easily | | | |  | Appears clumsy | | | |  |
| Sometimes falls out of seat | | | |  | Difficulty skipping, hopping jumping | | | |  |
| Appears stiff during physical activities | | | |  | Difficulty throwing | | | |  |
| Seems weaker than other children | | | |  | Difficulty catching | | | |  |
| Has obvious physical differences between right and left side | | | |  | Difficulty putting individual skills into sports/games | | | |  |
| Has difficulty coordinating both sides of body together | | | |  | Unable to participate in regular gym program | | | |  |
| Stumbles and falls more frequently than other children his/her age | | | |  | Has been referred to School District Physiotherapist | | | |  |
|  | | | | | | | | | |
| **Behaviour/Self-Regulation** | | | |  | **Sensory** | | | |  |
| Restless or overactive, constantly fidgets | | | |  | Dislikes rough-housing, somersaults, rolling on the floor, jumping | | | |  |
| Disorganized and messy desk | | | |  | Does not like to work/play with “messy” materials | | | |  |
| Inattentive, easily distracted | | | |  | Avoids being touched | | | |  |
| Fails to finish things he/she started | | | |  | Constantly touching objects/people | | | |  |
| Daydreams, cannot get started or work independently | | | |  | Avoids messy play/crafts | | | |  |
| Temper outburst, unpredictable or aggressive | | | |  | Seeks deep pressure | | | |  |
| Isolates him/herself from other children | | | |  | Needs tactile cues for direction | | | |  |
| Cannot follow directions | | | |  |  | | | | |
|  | | | | | | | | | |
| **Oral** | | | | | **Auditory** | | | | |
| Chews on clothes, pencil | | | |  | Covers ears | | | |  |
| Picky eater | | | |  | More difficulty in gym (PE, assemblies) | | | |  |
|  | | | |  | Distracted by sounds/noise | | | |  |
|  | | | | | Difficulty understanding verbal instructions | | | |  |
|  | | | | | | | | | |
| **Movement** | | | | | **Visual** | | | | |
| Constant body movement | | | |  | Difficulty visually attending to work | | | |  |
| Seeks swinging/rocking | | | |  | Difficulty copying from board | | | |  |
| Bumps into people/furniture | | | |  | Appears sensitive to light | | | |  |
| Fearful of activities moving through space | | | |  | Avoids eye contact | | | |  |
|  | | | |  | Visual input | | | |  |
|  | | | | | | | | | |
| **COMMENTS:** | | | | | | | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **This Section to be Completed by Parent/Guardian** | | | | |
| Please list any agencies and/or specialists currently or previously involved in your child’s care – include both educational and medical services. | | | | |
| Agency | Name of Specialist | Telephone No. | | |
|  |  |  | | |
|  |  |  | | |
|  |  |  | | |
|  |  |  | | |
|  |  |  | | |
|  |  |  | | |
|  | | | | |
| Was there ever any concern (by parent/guardian, other family members, doctors) with regard to your child’s: | | | | |
|  | | | YES | NO |
| Allergies | | |  |  |
| Feeding | | |  |  |
| Fine motor skills (grasping objects with fingers, etc.) | | |  |  |
| Gross motor skills (walking, running, etc.) | | |  |  |
| Language development (age at which first used words, etc.) | | |  |  |
| Articulation of words (speech) | | |  |  |
| Memory | | |  |  |
| Hearing | | |  |  |
| Vision | | |  |  |
| Activities of daily living (toileting, dressing, etc.) | | |  |  |
| Social skills (reluctance to play with others) | | |  |  |
| Emotions (excessive crying, insecurity, anxiety, etc.) | | |  |  |
| If there were concerns for any of the above, explain in more detail, include any other concerns  about your child. | | | | |
|  | | | | |
| Has your child had any serious illnesses, accidents or operations? If yes, please describe. | | | | |
|  | | | | |
| Is your child followed/been seen by a pediatrician? If yes, please elaborate. | | | | |
| Is your child presently on any medication? If yes, please list: | | | | |