Ontario Health atHome

REFERRAL FOR SCHOOL HEALTH SERVICES (SHS)
GENERAL INFORMATION & QUESTIONNAIRE

Student's Last Name:		First Name:	
Gender: ☐ Male ☐ Female		Date of Birth (DD/MM/YYYY):	
Health Card Number:		Version Code:	
Home Address:			Apt#:
City:	Province:		Postal Code:
☐ Mother ☐ Father ☐ Guardian		☐ Mother ☐ Father ☐ Guardian	
Name:		Name:	
Home: - -		Home: - -	
Cell: - -		Cell: - -	
Bus: - -		Bus: - -	
Languages Spoken in Home: ☐ English ☐ French ☐ Other: Interpreter required? ☐ No ☐ Yes ☐ Specify:			
School Name:		Grade:	
School Address:			
Telephone:		Fax:	

Services Requested	
☐ Occupational Therapy – *attach completed Request for OT Services*	☐ Nursing
☐ Physiotherapy – *attach completed Request for PT Services*	
☐ Speech Therapy – *attach completed Request for SLP Services*	

Additional Information
☐ Behavioural concerns:
☐ Safety concerns:
☐ Medical concerns/diagnosis:
☐ Other agencies involved with child:

Date Verbal Consent for Referral obtained from Parent/Guardian (DD/MM/YYYY)**:**

Referred by:

Date (DD/MM/YYYY)**:**

Please fax this referral to your nearest office:

Kirkland Lake	North Bay	Parry Sound	Sault Ste. Marie	Sudbury	Timmins
705-567-9407	705-474-0080	1-855-773 4056	705-949-1663	705-522-3855	705-267-7795

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Student's Last Name: _____ First Name: _____
Date of Birth (DD/MM/YYYY): _____

Please describe the reasons for the service(s) you are requesting. How does this student's difficulties impact his/her participation in school routines or ability to receive instruction?
Does the student have difficulty attending to task? Is he/she easily distracted?
Does this student receive help from the Resource Teacher or Educational Assistant? If applicable, describe.
What modifications, if any, have you implemented in support of the student (e.g., preferential seating, modified expectations, extra time, equipment, access to a computer in the classroom, writing program, lined paper, pencil grips, etc.)?
What specialized testing, if any, has been done or is scheduled (e.g. psychometric evaluation, language evaluation)?
Please provide any other information that you feel is important to understand the need for School Health Services.

Please attach all relevant documents and reports that will support this referral.

- ☐ Psychological Educational Assessment
- ☐ Previous Provider Report(s)
- ☐ Individual Education Plan (IEP)
- ☐ Medical/Specialist Report(s)
- ☐ Identification, Placement and Review Committee (IPRC)

Completed by:

Printed Name	Signature/Designation	Date (DD/MM/YYYY)

Ontario Health atHome

REFERRAL FOR SCHOOL HEALTH SERVICES (SHS)
REQUEST FOR OCCUPATIONAL THERAPY (OT) SERVICES

TO BE COMPLETED AND SUBMITTED WITH REFERRAL FOR SCHOOL HEALTH SERVICES WHEN OCCUPATIONAL THERAPY SERVICES ARE REQUESTED

Student's Last Name: _____ First Name: _____
Date of Birth (DD/MM/YYYY): _____

***Accessibility Transfers & Mobility (ATM)**:* Child has a disability related to long-term impairment such as trauma or surgery and requires assistance with accessing the school, safe transfers, mobility and positioning.
***Activities of Daily Living (ADL)**:* Child has delays in self-care which interferes with participation in school routines such as toileting, feeding and dressing.
***Productivity**:* Children who are 5 years or older whose performance is well below school curriculum expectations due to fine motor and/or visual motor/perception problems, despite implementation of school interventions/strategies. Child continues to have difficulty copying shapes and letters beyond the age at which the skills are acquired and letter/number reversals persist after grade 2.
***Sensory**:* Child has sensory processing issues such as sensitivity to noise, textures, lights, proximity to others and/or seeking tendencies such as mouthing objects which interfere with school participation/receiving instruction. The difficulty must be amenable to change and not solely from home-based sensory input such as clothing choices, snack textures. The child may demonstrate avoidance, self-stimulating behaviours, agitation, distress or fear.

Presenting issues (check all that apply):	***Note: Services are not provided for:***
☐ Past OT recommendations are no longer applicable/appropriate for the child ☐ Child requires assessment for adaptive equipment ☐ Child requires desk/chair modifications ☐ Child requires ADL devices/equipment (e.g. adapted feeding utensils) ☐ Pencil grasp/Pencil control skills ☐ Scissor use ☐ Printing legibility (e.g. letter sizing, spacing between words) ☐ Printing speed ☐ Eye-hand coordination ☐ Hand dominance ☐ Sensory (e.g., easily upset/distracted by loud or unexpected noises, bright lights, avoidance/ dislike the feeling of certain objects) ☐ Seeking tendencies (e.g. mouthing or sniffing objects) ☐ Rocking, swinging movements	• Assistive technology/resources/ accommodations already in place • ADL issues solely related to donning / doffing outdoor clothing • Children with disruptive wiggling and fidgeting behaviours or difficulties with executive functioning, self-regulation, organization and/or planning in the absence of sensory difficulties • Sporadic issues (i.e. not daily/constant) • Language based issues (e.g. spelling, Dyslexia) • Child requires left handed tools • Home-based issues (e.g., laces vs Velcro shoes) • Situations when required equipment (i.e., arm brace) can be sent to school from home

Completed by:	Date (DD/MM/YYYY):

Ontario Health atHome

REFERRAL FOR SCHOOL HEALTH SERVICES (SHS)
REQUEST FOR PHYSIOTHERAPY (PT) SERVICES

TO BE COMPLETED AND SUBMITTED WITH REFERRAL FOR SCHOOL HEALTH SERVICES WHEN PHYSIOTHERAPY SERVICES ARE REQUESTED

Student's Last Name: _____ First Name: _____
Date of Birth (DD/MM/YYYY): _____

***Gross motor (GM)**:* Child has a disability related to long-term impairment such as developmental coordination disorder, Muscular Dystrophy, Cerebral Palsy, Spina Bifida, trauma or surgery which impacts ability to participate in school routine/curriculum. Child has significant delays in development or difficulty coordinating movements such as stairs, ball skills, walking, running and poor physical endurance.
***Orthopedics**:* Child has a disorder related to an orthopedic condition impacting ability to attend school and participate in school routine. Child requires adaptive equipment to facilitate recovery and/or mobility while preventing injury to child and educators. School personnel to be provided with interventions and strategies when appropriate.
***Respiratory**:* Respiratory disorder resulting in lung secretions impacting breathing ability in school. (Doctors' orders must support need for service). PT will teach school personnel techniques and strategies.

Presenting issues (check all that apply):	***Note: Services are not provided for:***
☐ Difficulties have an impact on the child's safety or ability to participate in school curriculum/routine ☐ Child has delays result in inability to perform everyday age appropriate school related tasks. ☐ Child is 5 years or older and has a 12 – 18 month gross motor functional delay compared to age group. ☐ Child has issues with Range of Motion (ROM) and/or joint contractures that impact ability to participate in school curriculum/routine ☐ Child requires equipment which enables mobility/ROM ☐ Child has coordination problems affecting transfers, gait, postural control and safety ☐ Educator is able to apply interventions/teaching, provided by PT ☐ Child has lung secretions impacting breathing ability at school. (Must have a medical practitioner to provide care orders).	• Children with normal development • Has sustained a sport/recreation-related injury • Child who has developed musculoskeletal problems related to growth or weight gain

Completed by:	Date (DD/MM/YYYY):

Ontario Health atHome

REFERRAL FOR SCHOOL HEALTH SERVICES (SHS)
REQUEST FOR SPEECH LANGUAGE PATHOLOGY (SLP) SERVICES

TO BE COMPLETED AND SUBMITTED WITH REFERRAL FOR SCHOOL HEALTH SERVICES WHEN SPEECH LANGUAGE PATHOLOGY SERVICES ARE REQUESTED

Student's Last Name: _____ First Name: _____
Date of Birth (DD/MM/YYYY): _____

***Articulation**:* Child has difficulty producing sounds impacting intelligibility. Problem may arise from delay of, oral motor skills, trauma or disease process.
***Fluency**:* Lacking smoothness and/or flow of sounds, syllables, words and phrases so that intelligibility of speech is reduced, or child avoids certain sounds or communication situations. i.e., stuttering.
***Voice** (related to resonance or phonation):* Resonance from any part of the vocal tract that is altered or dysfunctional. Phonation problems such as pitch, loudness or intensity that originates in the vocal folds of the larynx.
***Dysphagia**:* Child has a swallowing impairment.

Check all that apply.	***Note: Services are not provided for:***
☐ Child is 5 and older and has difficulties articulating any of the following: **m, h, w, p, b, t, d, n, f, y *(yellow),* k and/or g** ☐ Child is 6 and older and has difficulty articulating any of the above sounds, and/or **v, ng, l and l-blends *(pl, bl, fl, kl, gl),* s and s-blends *(sp, sm, sn, sk, sl, sw, st)* and/or sh, ch, th, j (*jump*)** ☐ Child is 7 and older and has difficulty articulating any of the above sounds, and/or **z, r** ☐ Child stutters ☐ Child's voice sounds nasal, breathy or hoarse ☐ Child's pitch is too high or too low ☐ Child's voice is too loud or too quiet ☐ Child has a medical referral for a swallowing assessment	• Missing front teeth • A child has the skills, yet does not apply the knowledge, or is not motivated to improve • Child's speech sounds are mildly delayed (e.g. 2 or less inconsistent speech sound errors); • Child is receiving home-based services from the Children's Treatment Centre; • Difficulties are academic-based (e.g. language, spelling and printing) • Delay of receptive and/or expressive language • Augmentative Communication needs

Completed by:	Date (DD/MM/YYYY):