Ontario
Health atHome

☐ Chatham Branch
Tel: 519 351-5677
Fax: 519-351-5842

☐ Sarnia Branch
Tel: 519-337-1000
Fax: 519-337-4331

☐ Windsor Branch
Tel: 519-258-8211
Fax: 519-258-6288

Children's Health School Services Program – Referral

Referral ☐ New ☐ Re-referral *(A consultation with a Care Coordinator is required prior to re-referral)*

☐ **Parent/Guardian has agreed to this referral**

Name: _____ DOB: _____ (dd/mm/yy)

Health Card Number: _____ VC: _____ Gender: ☐ Male ☐ Female

Home Address: _____

City: _____ Province: _____ Postal Code: _____

Mailing Address (if different than home address): _____

City: _____ Province: _____ Postal Code: _____

Family Physician: _____

Medical/Developmental Conditions: _____

Parent/Guardian Contact Information

☐ Mother ☐ Father ☐ Guardian

Name: _____

Phone Number: _____

Home: _____

Cell: _____

Business: _____

☐ Mother ☐ Father ☐ Guardian

Name: _____

Phone Number: _____

Home: _____

Cell: _____

Business: _____

Other Emergency Contact:

Name: _____ Relationship: _____ Phone: _____

School Information

School Name: _____ City: _____ Grade: _____

Address: _____ Fax: _____

Principal: _____

Classroom Teacher: _____

Education Assistant: _____

Learning Resource Teacher: _____

Other Personnel: _____

Class Placement: ☐ Regular ☐ Special Education ☐ DD/Life Skills ☐ Other: _____

School Board Assessments Requested or Completed:

☐ Speech Language ☐ Psychoeducational ☐ Other:

Is Behaviour Team Involved? ☐ Yes ☐ No

Student Receiving Resource Assistance: ☐ Yes ☐ No

Has an IPRC Been Held? ☐ Yes ☐ No

Name: _____ DOB: _____
(dd/mm/yy)

Referral Information: Publicly Funded Schools

Service Requested: ☐ Nursing

Comments:

Referral Information: Private School /In-Home School

Service Requested ☐ Occupational Therapy ☐ Physical Therapy ☐ Speech Therapy

☐ Nursing ☐ Personal Support Worker (PSW)

Comments:

Please identify the forms which have been completed and are included with this referral:

☐ Teacher Checklist (required for Occupational Therapy/Physiotherapy referrals)

☐ School Board Speech Language Pathologist's Referral (required for Speech Therapy referrals)

☐ Other reports to support the need for assessment

Referral Initiated by: _____

Person to Contact at School for Further Information: _____

Contact Number: _____ Best Time to be Reached: _____

Additional Information Requested: (to be completed by Publicly Funded and Private/Home Schools)

Please describe in detail the reason for this referral:

Please describe the strategies employed to date to address these concerns (i.e., Classroom Accommodations, Learning Support Teacher involvement; Special Education consultation, Therapies received):

Is the student functioning at grade/developmental level in all areas? ☐ Yes ☐ No
If no, describe areas of difficulty:

Current/Previous Agencies Involved:

_____ _____
Principal / Designate Signature Print Name / Title

_____ _____
School Board / Agency Date (dd/mm/yy)