Ontario
Health atHome

Request for School Health Support Services

356 Oxford Street West London, ON N6H 1T3
Telephone: 1-877-900-5667 Fax: 519-657-4578

PATIENT INFORMATION

Surname		First Name	
Health Card Number (HCN)	Version Code	Date of Birth (YYYY-Month-DD)	Gender

FAMILY INFORMATION

Primary Parent/Guardian Name		Secondary Parent/Guardian Name	
Primary Parent/Guardian Business/Mobile Telephone Number		Secondary Parent/Guardian Business/Mobile Telephone Number	
Permission to Contact at Work ◯ No ◯ Yes	Informed Consent Received ◯ No ◯ Yes	Permission to Contact at Work ◯ No ◯ Yes	Informed Consent Received ◯ No ◯ Yes

Mailing Address

City	Postal Code	Telephone Number
Children's Aid Society (CAS)/Homeshare/Other Contact	Date Referral Initiated (YYYY-Month-DD)	
Referral Initiated by	Relationship to Patient	Telephone Number
Family Physician	Specialist	

Known Diagnosis

SCHOOL INFORMATION

School	Telephone Number
Attendance ☐ AM ☐ PM ☐ Full Day ☐ Alternate Days	Grade

Principal	Teacher	Resource Person

School personnel responsible for follow-up of recommendations provided by therapy

Name	Telephone Number	Best Time to Call

REFERRAL INFORMATION

Assessment Requested

☐ Occupational Therapy (OT) ☐ Physiotherapy (PT) ☐ Speech Language Pathology (SLP) ☐ Nursing ☐ Personal Support Work (PSW)

List or attach any specialized testing (e.g. psychology, psychometry, speech, agency/treatment centre, etc.)

What interventions have been implemented to accommodate this student's strengths and needs?

REFERRAL AUTHORIZATION DETAILS

Name of Staff Authorizing Referral (School Principal/Designate)

Title/Designation of Authorizing Staff

Referrer Signature

Date Signed (YYYY-Month-DD)