REFERRAL FOR ELIGIBILITY SCREEN FOR SBRS SLP FOR KINDERGARTEN STUDENTS (JK/SK)

REFERRAL INFORMATION
(To be completed by the school)

STUDENT INFORMATION

Last Name: ______ First Name: ______

Date of Birth: *(dd-mmm-yyyy)* ______ Gender: ______ Primary Phone: ______

Address: ______ City: ______ Prov: ______ Postal Code: ______

PARENT/GUARDIAN INFORMATION

Primary Contact Last Name: ______ First Name: ______

Relationship to Child: ______ *(if Other or Agency, please specify)* ______

(check all that apply) Legal Guardian Lives with Child I give consent for email communication

Primary Phone: ______ Other Phone: ______ email: ______

Address is… ☐ same as child's above-listed address ☐ other than above-listed address *(if other, provide below)*

Address: ______ City: ______ Prov: ______ Postal Code: ______

Second Contact Last Name: ______ First Name: ______

Relationship to Child: ______ *(if Other or Agency, please specify)* ______

(check all that apply) Legal Guardian Lives with Child I give consent for email communication

Primary Phone: ______ Other Phone: ______ email: ______

Address is… ☐ same as child's above-listed address ☐ other than above-listed address *(if other, provide below)*

Address: ______ City: ______ Prov: ______ Postal Code: ______

DECISION-MAKING RESPONSIBILITY

No formal agreement Formal agreement in place Parents live together with child

If formal agreement in place, please describe (e.g., sole, joint, etc.) ______

If parents not together, all legal guardians are aware of and have consented to this referral: ☐ N/A ☐ Yes ☐ No

Other: If No, referral cannot be processed

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Child's Last Name ***DOB:*** *(dd-mmm-yyyy)*

Child's First Name

ADDITIONAL INFORMATION

Language(s) Spoken/Understood by Child: Interpreter required? ☐ Yes ☐ No

Does the student have an individualized Education Plan (IEP)? ☐ Yes ☐ No *(if Yes, please attach)*

Does the student have an Identification, Placement and Review Committee (IPRC) designation? ☐ Yes ☐ No

(if Yes, briefly identify exceptionality)

Is there a Safety Plan for this student? ☐ Yes ☐ No

(if Yes, briefly describe)

Has the school completed any other assessments or testing with this student? ☐ Yes ☐ No

(if Yes, briefly provide details)

School Board: ☐ ALCDSB ☐ HPEDSB ☐ CEPEO ☐ CECCE ☐ PDSB (Provincial & Demonstration)

School: City:

Learning Support Teacher: LST's email:

Classroom Teacher Grade:

Principal: Phone:

REFERRAL SOURCE

Referred by: Date: *(dd-mmm-yyyy)*

Signature: *(type name to sign form electronically)*

265 Dundas St. E., Belleville, ON. K8N 5A9 | https://quintectc.com

Tel: 613-969-7400 ext. 2784 | Fax: 613-961-2517

CONSENT FOR ELIGIBILITY SCREEN FOR SBRS SLP FOR KINDERGARTEN STUDENTS (JK/SK)

Child's Last Name ***DOB:*** *(dd-mmm-yyyy)*

Child's First Name

This consent form should generally be completed by the parent/guardian. Alternatively, school staff may review the information with the parent/guardian and complete the form on their behalf.

!Name of person providing consent:

!Relationship to student of the person providing consent:

CONSENT TO REFERRAL:

I/we consent to a referral to the Quinte Children's Treatment Centre (QCTC) for a speech eligibility evaluation for the above-named student. The purpose of this evaluation is to determine if a formal referral to the School-Based Rehabilitation Services Speech Language program is required. I/we understand that I/we will be contacted by the QCTC prior to the evaluation in order to obtain my/our consent to proceed. I/we also authorize the QCTC to collect, use and disclose relevant information regarding my student for eligibility determination and prioritization, and for QCTC to share information with my student's school/school board regarding my student's speech need, as required. Information will only be exchanged with those agencies listed below if they are involved in the care of my child and is to be used for the purpose of coordinating services.

Consent for Sharing of Information

Services work best when there is good communication among everyone involved with you and your child

I do hereby authorize the exchange of information to and from: *(please check all that apply)*

- ☐ QCTC with school board *(specify school board)*
- ☐ QCTC with physician(s) *(specify physician's name)*
- ☐ QCTC with Organization/Agency *(specify)*
- ☐ QCTC with another Children's Treatment Centre *(specify city/area)*

Quinte Children's Treatment Centre is committed to your privacy and is compliant with the Ontario Personal Health Information Protection Act. This authorization is valid for as long as my child is receiving services through the QCTC. This authorization may be withdrawn at any time by submitting a written request to the QCTC at the above address.

Signature: *(you may electronically sign by typing name below)* **Date:** *(dd-mmm-yyyy)*

If written consent cannot be obtained, a representative of the school may document verbal consent, as follows in the signature box:

"Verbal consent obtained from by

(school staff)"

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