REFERRAL REQUEST

Children's Treatment Centre
Quinte Health
School-Based Rehabilitation Services

How to refer:

- Please complete all fields and be sure to download/save the completed form to your computer/device to avoid submitting a blank form. If a blank or incomplete form is submitted using the secure upload method, there is no way to identify and notify the sender.
- Secure electronic upload (please see instruction on our website *www.quintectc.com*) ***or*** Fax to 613-961-2517

Questions? Call 613-969-7400 ext. 2784

SERVICES REQUESTED

☐ *Occupational Therapy ☐ *Physiotherapy ☐ *Speech Therapy

☐ Urgent equipment needs required for school entry (i.e., ramp, grab bars, mobility device)

☐ Request for service in French – if attending French school

**Supporting documentation must accompany referral*

YOUTH/CHILD INFORMATION

Last Name: First Name:

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

Address: City: Prov: Postal Code:

PARENT/GUARDIAN INFORMATION

Primary Contact Last Name: First Name:

Relationship to Child: (select relationship) *(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: (select relationship) *(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:

REFERRAL REQUEST

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

Child's First Name

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

If No, referral cannot be processed

ADDITIONAL INFORMATION

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

Diagnosis(es), if any:

Other services involved (e.g., CAS)

Primary Physician: Phone/Extension:

Other Physician: Phone/Extension:

SCHOOL INFORMATION

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)*