

SBRS SLP Kindergarten (JK/SK) Eligibility Screen Referral Form

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)

Consent for SBRS SLP Kindergarten (JK/SK) Eligibility Screen

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)"