Southwest
COLLABORATIVE SUPPORT SERVICES

Regional Rehabilitation (SLP, OT, PT) Service Request

CHILD/YOUTH INFORMATION	Last Name:	First Name:	Grade:
	Date of Birth: (yyyy/mm/dd)	Program Unit Funding (PUF): ☐ Yes	
	School:	Teacher:	

PARENT/ LEGAL GUARDIAN INFORMATION	Last Name:	First Name:	☐ Parent ☐ Legal Guardian
	Address:	Cell:	Work:
	Email:		
	Last Name:	First Name:	☐ Parent ☐ Legal Guardian
	Address:	Cell:	Work:
	Email:		

REFERRER'S INFORMATION	☐ Parent/Guardian ☐ AHS ☐ School Division ☐ Community Agency Date: (yyyy/mm/dd)		
	Organization:		
	Referrer's Name:	Phone:	Ext
	Title:	Email:	
	(**For schools only**) This request has been discussed with the school Administrator ☐ ***No*** ☐ ***Yes***		
The referrer has obtained informed consent from the parent or legal guardian for this request ☐ ***No*** ☐ ***Yes***			

☐ Requesting support regarding **SPEECH/LANGUAGE** concerns. **Complete yellow column**	☐ Requesting support regarding **PHYSIOTHERAPY** concerns **Complete blue column**	☐ Requesting support regarding **OCCUPATIONAL THERAPY** concerns **Complete green column**
Background information attached: ☐ Prior assessment report ☐ Prior treatment summary / report	**Background information attached**: ☐ Prior assessment report ☐ Prior treatment summary / report	**Background information attached**: ☐ Prior assessment report ☐ Prior treatment summary / report
The child/youth: ☐ Has received a diagnosis: _____ ☐ Utilizes assistive technology: ☐ PODD Book ☐ Communication device ☐ Other	**The child/youth:** ☐ Has received a diagnosis: _____ **The child/youth requires support:** ☐ for mobility (ex. walking, running, wheelchair propulsion) ☐ with adaptive equipment (ex. wheelchair, walker, standing frame) ☐ with transfers ☐ with participation in school, including gym/recess	**The child/youth:** ☐ Has received a diagnosis: _____ ☐ **The school team** has reviewed the OT Universal Strategies document (on www.swcss.ca) and implemented some of the suggested strategies prior to making this referral.

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Who else is supporting the student?

✓ Currently	✓ Previously		✓ Currently	✓ Previously	
		Assistive Technology Consultant			Occupational Therapist
		Audiologist			Orientation And Mobility Specialist
		Behaviour Specialist			Physical Therapist
		Counsellor (FSLC / School)			Psychiatrist
		Educational Assistant			Psychologist
		Hearing Consultant			Speech Language Pathologist
		Learning Support Teacher			Vision Consultant
		Mental Health Therapist			Other:

Reason for request:

The child/youth:

- ☐ Has a peer group at school
- ☐ Struggles to communicate with teacher / EA
- ☐ Is struggling academically
- ☐ Struggles to follow directions/answer questions
- ☐ Has difficulty telling a story

Child/youth strengths and interests:

What strategies have been tried?

What strategies are the most effective?

Instructions to submit form electronically:

1. Complete and save this form
2. Complete Consent for Service/Release of Information document and have parent/guardian
3. Scan consent, attachments/reports
4. Email documents to your Central Office designate who will review the referral and upon approval, will forward to the SWCSS Regional Rehab Therapist Team to commence service.