Southwest
COLLABORATIVE SUPPORT SERVICES

Low-Incidence Service Request

CHILD/YOUTH INFORMATION	Last Name:	First Name:	Grade:
	Birth date: (yyyy/mm/dd)	PUF: ☐ ELL: ☐	CODE(s): _____
	School Division:	School:	
	Teacher:	Classroom teacher email:	
	If Pre-K, what days / times does child attend program? _____		

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	Referrer's Name:	Phone:	Date: (yyyy/mm/dd)
	Title:	Email:	
	Prior to referral, the school team has: • reviewed previous reports/recommendations in student's permanent file • attended SWCSS Office Hours session to consult about student needs • obtained and attached consent from the parent/guardian for this referral		☐ ***No*** ☐ ***Yes*** ☐ ***No*** ☐ ***Yes*** ☐ ***No*** ☐ ***Yes***

☐ Requesting support regarding **HEARING** concerns **Complete yellow column**	☐ Requesting support regarding **VISION** concerns **Complete blue column**
Hearing assessment helpful but not required. ☐ Audiogram attached	**Vision report required**, attach either: ☐ Ophthalmology report ☐ Optometry report
The child/youth: ☐ Has been diagnosed with a hearing loss ☐ Wears amplification: ☐ Cochlear Implant ☐ Hearing Aid ☐ Uses a DM system: type: _____ ☐ Uses an alternative communication system: ☐ American Sign Language ☐ Signed Exact English ☐ PODD Book ☐ Communication device ☐ Other ☐ Has an interpreter	**The child/youth:** ☐ Is legally blind/registered with CNIB ☐ Has recently experienced vision loss ☐ Has a reduced field of vision ☐ Has limited visual acuity ☐ Has low vision ☐ Is having difficulty with orientation and mobility ☐ Needs assistive technology (ex. magnifier) ☐ Needs appropriate reading and writing media (ex. large print, braille, audio) ☐ Please provide ASN for SSVI loans _____

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What struggles/challenges does the child have in school, or with peers, that may be supported by the Low Incidence team?

The child/youth:

- ☐ Frequently asks for things to be repeated
- ☐ Struggles to communicate/engage with peers
- ☐ 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 form, print, and have parent/guardian sign and return
3. Scan consent, attachments/reports (reminder: vision report is required, audiogram is optional)
4. Email documents to your Central Office designate who will review the referral and upon approval, will forward to the SWCSS Regional Low Incidence Team to commence service.