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)	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:	
	Background information is attached:	☐ Prior assessment report ☐ Prior treatment summary / reports	

Prior to referral, the school team has:

- reviewed previous reports/recommendations in student's permanent file ☐ ***No*** ☐ ***Yes***
- tried universal strategies (see swcss.ca under Accessing Services menu) ☐ ***No*** ☐ ***Yes***
- attended SWCSS Office Hours session to consult with a therapist ☐ ***No*** ☐ ***Yes***
- obtained and attached consent from the parent/guardian for this referral ☐ ***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**
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 participation in school, including gym/recess	**The child/youth:** ☐ Has received a diagnosis: ______________________

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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 Support Teacher			Speech Language Pathologist
		Learning Support Teacher			Vision Support Teacher
		Mental Health Therapist			Other:

What struggles/challenges does the child have in the classroom, or with peers, that may be supported by the Rehab team? Be specific for each service (SLP, OT, PT) requested.

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

For speech / language referrals:

- ☐ The child/youth's level of speech/language has significant impact on their social interactions / learning

Estimate the % of speech you can understand ___________

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 and have parent/guardian sign and return
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.