



School-based rehabilitation services

Referral form



Referral Form for Grandview Kids School-Based Rehabilitation Services

Before you submit

Please ensure this referral form is completed in full. All referrals require the completion of all sections:

Section 1: Information sharing and agreement to referral

Section 2: Student information

Section 3: Parent/legal custodian information

Section 4: Additional parent/legal custodian information

Section 5: School information

Services being requested:

Occupational therapy referral information (Complete Section 6)

Physiotherapy referral information (Complete Section 7)

Speech therapy referral information (A SLP must complete Section 8)

To submit:

Secure Access email: service.navigation@grandviewkids.ca

Fax: 1-855-698-4725

1. Information sharing and agreement referral

In order to facilitate the referral and school-based rehabilitation services (SBRS), information between Grandview Children's Centre, the school and school board, as well as any Service Provider Organization assigned by Grandview Children's School (their agents), will need to be shared. This shared information will include contact information and demographic information. It may include assessment, diagnostic, treatment or medical history related to the SBRS, which includes Occupational Therapy, Physiotherapy and Speech-Language Pathology.

I agree to a referral to the School-Based Rehabilitation Program administered by Grandview Children's Centre

The purpose of information sharing has been fully explained to me and I have had the opportunity to ask questions.

I authorize the sharing of information related to the School-Based Rehabilitation Program between Grandview Children's Centre and the School/School Board as per the purposes described.

Date:

Print name:

Relationship to student:

Signature of Student (if 16 years or older) or Parent/Legal Custodian

OR

Verbal agreement provided by:

Date:

Name of Student (if 16 years or older) or Parent/Legal Custodian

Date:

Print name and designation:

Signature of Principal/Designate:

2. Student information

First name:	Last name:	
Gender:	Date of Birth:	
Diagnosis (if known):		
Language spoken in the home:	Interpreter required: Yes No	Services requested in: English French
Street address:	City/town:	
Postal code:	Home phone number:	

3. Parent/legal custodian information

Parent/legal guardian name:		
Relationship to child:	Legal custodian: Yes No	Living with child: Yes No
Address:	Same as client	
Primary phone number:		
Secondary phone number:		
Email address:		

4. Additional parent/legal custodian information

Parent/legal guardian name:		
Relationship to child:	Legal custodian: Yes No	Living with child: Yes No

Address:	Same as client
Primary phone number:	
Secondary phone number:	
Email address:	

5. School information

School name:		
School Board name:		
School address:	City/town:	
Postal code:	Phone number:	
Grade:	Small class placement: Yes No	Type:
If applicable, provide details about the student's modified day schedule (times/days attending):		
In-school resource team contact name:		
Role:	Phone number and extension:	

Education supports currently being accessed that impact on service sought through this referral: *Please list service and contact information with parent/caregiver agreement.*

Previous school-based rehabilitation services:

Occupational therapy

Physiotherapy

Speech-language pathology

Date of discharge (if known):

IEP in place:

Yes

No

Select which specialized equipment is currently in use:

Laptop

Mobility aids

Bathroom equipment,
specify:

Vision aids

Specialized desk

Sensory equipment,
specify:

Hearing aids

Alternative positioning

Transfer equipment,
specify:

Communication
devices

This equipment is:

Student-specific

Available in the classroom/school

Describe the strategies or equipment you have already tried:

Examples: pencil grips, wiggle seats, noise cancelling earphones, visual schedules, timers, movement breaks, laptop, fidgets, data collection.

6. Occupational therapy referral information

Describe your primary concerns pertaining to the referral of the student in your classroom. *Please provide some examples.*

Areas of concern

Not related to behaviour but is a physical or functional difficulty.

Fine motor:

Scissor

Need for technology to support written work

Printing

Legibility

Speed

Reversals

Spacing/line use

Self-care

Toileting (not toilet training)

Dressing

Self-feeding

Equipment

Bathroom

Positioning

Alternate seating/desk

Attention

Task completion

Remain seated

Following multi-step directions

Pain impacting participation/function:

Endurance:

How often are these issues affecting the student's ability to access the curriculum?

Never

Rarely

Sometimes

Often

Unable to access school/program environment

Sensory/self-regulation

Behavioural concerns

Behaviours	Yes	No
Behaviour occurs across multiple environments		

Behaviours	Yes	No
Behaviour is often repetitious		
Behaviour occurs when student is alone and or unoccupied, not to gain attention from others		
Escape/flight occurs when student is trying to avoid a person or task		
Escape/flight occurs when student is attempting to gain attention		

Causing injury to:

Self

Others

Not applicable

How often are these issues affecting the student's ability access the curriculum?

Never

Rarely

Sometimes

Often

Unable to access school program/environment

The following may not be typical sensory related behaviours and a referral to Behaviour Consultant should also be considered:

Behaviour occurs to get a preferred item, to gain attention, or avoid participating in an undesirable activity

Behaviour is intentionally aggressive towards people or property

Behaviour and Attention are reasons for falling, difficulty with stairs or running away

*** If clarification is required please reach out to primary SBR OT for your school*

What are your goals for this student related to this request (be specific)?

Recommendations/modifications to environment

Staff/caregiver education

Activity suggestions

Equipment

Comments:

7. Physiotherapy referral information

Describe your primary concerns pertaining to the referral of the student in your classroom. Please provide some examples.

Areas of concern

Not related to behaviour but is a physical or functional difficulty

Gross motor

Transfers

Gym program

Playground

Access to building/stairs

Equipment

Lifts and transfers

Fire evacuation

Positioning

Mobility

Balance or coordination difficulty impacting school program or access (falling unrelated to behaviour)

Post-surgical changes impacting mobility or gross motor function in school program or environment

Pain impacting mobility or gross motor function in school program or environment

Decreasing activity tolerance/endurance impacting mobility or gross motor function in school program or environment

What are your goals for this student related to this request? *Be specific:*

Recommendations/modification to environment

Staff/caregiver education

Modifications to gym curriculum

Equipment

Comments:

To be completed by Speech Language Pathologist

8. Speech therapy referral information (sound production only)

Describe your primary concerns pertaining to the referral of the student in your classroom. *Please provide some examples.*

Hearing:

History of ear infections

Recent hearing test

Not assessed

Results of hearing test:

Date:

Language Development:

Within normal limits

Pragmatic language

Difficulty with:

Sentences

Vocabulary

Expressive language

Receptive language

Comments:

Section A: Articulation/phonology concerns

Moderate

Severe

Students with mild articulation or phonology problems (<3 sound errors) are ineligible.

Check errors and list in section below:

Front deletion
Vowel distortion
Cluster reduction
Gliding
Weak syllable
Backing

Final consonant deletion
Initial consonant deletion
Omissions
Deaffrication
Distortions

Interdental production
Lateral production
Single error sounds
Stopping
Other

Level of intelligibility in connected speech:

More than 80%

Between 50% to 80% with careful listening

Less than 50% of the time with familiar listens and known context

Sound	Please Check ✓		Position(s)	Sound	Please Check ✓		Position(s)
	Delayed	Distorted			Delayed	Distorted	
1.				2.			
3.				4.			
5.				6.			
7.				8.			

Section B: Motor speech/Dyspraxia

Mild

Moderate

Severe

Indicators of motor speech difficulties

Impaired respiratory support for speech

Effortful groping

Impaired motor control of facial-lip movements

Imprecise speech

Impaired motor control of jaw movements

Tone or structural issues that impact on speech

Impaired motor control of tongue movements

Distorted vowel production

Imprecise consonant production

Voicing/voiceless errors

Difficulty initiating speech

Preservative, anticipatory and/or transposition errors

Difficulty sequencing

Automatic utterances better than volitional

Increased errors as phonemic sequence increases

Comments:

Section C: Fluency concerns

Mild

Moderate

Severe

Dysfluencies observed/reported

Stuttering longer than 12 months

Over time frequency or severity has increased

Blood relative with stuttering past 7 years of age

Has speech production difficulties

Previous intervention for fluency

Demonstrates secondary characteristics (describe):

Comments:

Section D: Voice/Resonance concerns

Mild

Moderate

Severe

Child must have a recent ENT assessment for Voice Referral to be accepted (within last 6 months)

Date of ENT Assessment:

Cleft palate:

Yes

No

Involved with Cleft Palate Team

Yes

No

Voice Quality	Normal	Difficulties
Pitch/Intonation	Normal	Difficulties
Volume	Normal	Difficulties
Surgery	Yes No Unknown	Date: Type:
Resonance	Hypernasal Hyponasal Nasal Emission	
Vocal nodules	Yes No	

What are your goals for this student related to this request? *Be specific:*

Recommendations/modification to environment

Staff/caregiver education

Coaching and direct treatment

Comments:

SLP Assessment Completed by:

Date:

SLP Organization/Employer: