Referral Form for Grandview Kids
School-Based Rehabilitation Services

This form is intended to be printed and faxed to 1-855-698-4725.

Before you submit

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

- ☐ Section 1: Release of information and consent 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)

1. Release of information and consent to 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.
- ☐ I understand that I may withdraw my consent at any time by contacting Grandview Kids. Otherwise, the consent will remain valid until discharge from the SBR program.

Student (if 16 years or older) or Parent/Legal Custodian Signature	Print name and relationship	Date
OR Verbal consent provided by: Name of student or Parent/Legal Custodian:		Date:
Principal/Designate signature	Name and designation	Date

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 (extension):	

Is the student currently accessing any of the following?

Service	Yes	No
Augmented Classroom Support Staff* *EA/interpreter/intervener	○	○
Autism Consultant/Team:	○	○
Behavioural Consultant:	○	○
Board Psychological Services:	○	○
District School Board SLP and/or CDA	○	○
District School Board OT (TDSB)	○	○

Service		Yes	No
District School Board PT (TDSB only)		○	○
Private SLP service	○ Yes	○ No	○ Unknown
Private OT service	○ Yes	○ No	○ Unknown
Private PT service	○ Yes	○ No	○ Unknown

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
- ☐ Vision aids
- ☐ Hearing aids
- ☐ Communication devices
- ☐ Mobility aids
- ☐ Specialized desk
- ☐ Alternative positioning
- ☐ Bathroom equipment, specify: _____
- ☐ Sensory equipment, specify: _____
- ☐ Transfer equipment, specify: _____

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	○	○

Behaviour is often repetitious	◯	◯
Behaviour occurs when student is alone and or unoccupied, not to gain attention from others	◯	◯
Escape/Flight is related to avoiding a person or task or attention driven behaviour	◯	◯

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	☐Weak syllable	☐Omissions	☐Lateral production
☐Vowel distortion	☐Backing	☐Deaffrication	☐Single error sounds
☐Cluster reduction	☐Final consonant deletion	☐Distortions	☐Stopping
☐Gliding	☐Initial consonant deletion	☐Interdental production	☐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	☐ Tone or structural issues that impact on speech	☐ Difficulty initiating speech
☐ Effortful groping	☐ Impaired motor control of tongue movements	☐ Preservative, anticipatory and/or transposition errors
		☐ Difficulty sequencing

- ☐ Impaired motor control of facial-lip movements
- ☐ Imprecise speech
- ☐ Impaired motor control of jaw movements
- ☐ Distorted vowel production
- ☐ Imprecise consonant production
- ☐ Voicing/voiceless errors
- ☐ 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 7years 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:_____