

School Health Support Services (SHSS) Referral Form

Telephone: 416-222-2241 or 905-895-1240 or 1-888-470-2222 Fax: 416-222-6517 or 905-952-2404

*Incomplete referrals will NOT be processed

A. STUDENT AND PARENT/GUARDIAN INFORMATION

Student Name: _____ Male
 _____ Female
(Last Name) (First Name)

Date of Birth: _____ **Health Card Number:** _____
(dd-mmm-yyyy) (Version Code)

Home: _____
(Address) (City/Town) (Postal Code)

Primary Language: _____ **Secondary Language:** _____

Parent/Guardian

<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Guardian	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Guardian
Name: _____	Name: _____
Home #: _____	Home #: _____
Cell #: _____	Cell #: _____
Business #: _____ Ext.: _____	Business #: _____ Ext.: _____

Referral initiated at parent(s) request: Please specify parent(s) main concern: _____

B. PHYSICIAN/MEDICAL INFORMATION

Physician Name: _____ **Phone #:** _____ **Ext.:** _____

Relevant Medical Information/diagnosis/syndrome(s): _____

C. SCHOOL INFORMATION

TDSB YRDSB SCDSB CSDCCS Private School Home School
 TCDSB YCDSB SMCDSB CSDCSO Preschool Program

School Name: _____
School Address: _____
Phone #: _____ **Ext.:** _____ **Fax #:** _____
Principal/Vice Principal: _____
Teacher: _____ **Grade:** _____
Principal/Designate: _____ **Date:** _____
(Signature) (dd-mmm-yyyy)

D. SCHOOL BOARD CONSULTANT INFORMATION
 Not Applicable

A School Board Consultant's report and signature are required from school boards that have Occupational Therapy/Physiotherapy/Speech Language Pathology consultants. Report Attached

Consultant Name: _____ **Phone #:** _____ **Ext.:** _____

Please specify the main concern: _____

Consultant: _____ **Date:** _____
(Signature) (dd-mmm-yyyy)

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Student Name: _____
(Last Name) (First Name)

Date of Birth: _____
(dd-mmm-yyyy)

School Name: _____

E. Service Requested

Safety Concern – Is there an immediate safety concern? Yes No
 If yes, please describe the safety need and related plan: _____

Speech Language Pathology (SLP)

Articulation/Phonology/Motor Speech Delay/Disorder Moderate Severe
 Fluency Disorder Moderate Severe
 Resonance Disorder Moderate Severe
 Voice Disorder ENT report available: Yes No
 Oral Motor Involvement
 Please provide specific details about the student's communication needs:

What strategies have been trialled? _____

What services have been accessed to date? _____

Occupational Therapy (OT)

Moderate **Severe**

<input type="checkbox"/> Fine Motor/Motor Coordination:	<input type="checkbox"/> Sensory Processing:	<input type="checkbox"/> Functional Abilities:	<input type="checkbox"/> Visual/Motor:
<input type="checkbox"/> Printing	<input type="checkbox"/> sensitivity to light sound	<input type="checkbox"/> dressing	<input type="checkbox"/> difficulty copying from white/black board
<input type="checkbox"/> in-hand manipulation	<input type="checkbox"/> touch	<input type="checkbox"/> feeding	<input type="checkbox"/> loses place when reading
<input type="checkbox"/> scissor use	<input type="checkbox"/> constant movement	<input type="checkbox"/> toileting	<input type="checkbox"/> reverses letters
<input type="checkbox"/> tires easily	<input type="checkbox"/> repetitive behaviours	<input type="checkbox"/> transfers	<input type="checkbox"/> difficulty finding things in desk/shelf
<input type="checkbox"/> organizing work	<input type="checkbox"/> difficulty with personal space		<input type="checkbox"/> unable to scan page
<input type="checkbox"/> weak/tight muscle movements	<input type="checkbox"/> seeks/avoids textures		
	<input type="checkbox"/> presses too hard/light when writing/drawing		

Specialized equipment/technology needs (please specify): _____

Please provide specific details about the student's needs:

What strategies have been trialled? _____

What services have been accessed to date?
