# School Community Intervention Partnership (SCIP)
# School Referral Form

**Please review the SCIP School Referral Package and Checklist, as well as the SCIP Criteria for Service document prior to completing this referral.**

**Thank you for completing all sections of this referral.**
Please send completed referral to the SCIP Team by email: SCIP@wellkin.ca or fax: 519-539-7058

Date Referral Completed: ______________________

☐ LDCSB ☐ Oxford County
☐ TVDSB ☐ Elgin County

## Student Information

| | | | |
|---|---|---|---|
| Name: | | Address: (Including Postal Code) | |
| Date of Birth: (Y/M/D) | | | |
| Age: | | | |
| Gender: | ☐ Male ☐ Female ☐ Another Gender Identity | | |
| Telephone #: | | | |
| Has **parent/guardian** given consent for SCIP to leave a message at this number? ☐ Yes ☐ No | | | |

## School Information

| | | | |
|---|---|---|---|
| Referring School: | | Address: | |
| Telephone #: | | | |
| Grade: | | Class Size: | |
| Principal: | | | |
| Teacher: | | Teacher's Email: | |
| **Current and Past School Based Resources** | | | |
| **Psychology Services** | ☐ Yes ☐ No | **Social Worker/School Support Counsellor** | ☐ Yes ☐ No |
| If yes, when? | | If yes, when? | |
| Name: | | Name: | |
| Telephone #: | | Telephone #: | |
| Email: | | Email: | |



Form Updated September 2020

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| **Behavioural Services** ☐ Yes ☐ No | **LST/SPST** ☐ Yes ☐ No |
|---|---|
| Are they aware of this referral? ☐ Yes ☐ No | Are they the Primary contact person? ☐ Yes ☐ No |
| If yes, when? | If yes, when? |
| Name: | Name: |
| Telephone #: | Telephone #: |
| Email: | Email: |
| If the LST/SPST is not the Primary Contact, who is? | |
| Name | Telephone #: |
| Email: | |

### Parent/Guardian Information

| | |
|---|---|
| Name: | Address: |
| Relationship: | (If different from child.) |
| Custodial Parent: ☐ Yes ☐ No | |
| Telephone #: | Email: |
| Has **parent/guardian** given consent for SCIP to leave a message at this number? ☐ Yes ☐ No | |
| Name: | Address: |
| Relationship: | (If different from child.) |
| Custodial Parent: ☐ Yes ☐ No | |
| Telephone #: | Email: |
| Has **parent/guardian** given consent for SCIP to leave a message at this number? ☐ Yes ☐ No | |

### Reason for Referral

| Please provide details regarding the child's difficulties in regulating their behaviours. Please include/comment on academics, attendance, and social/peer relations. Please also include any strategies already implemented in an effort to support the child. |
|---|

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| School's view of the child's strengths: |
|---|
| School's view of the child and family's needs: |
| School's expected outcomes/goals for this child: |

| **Current and Past Classroom Supports** | | |
|---|---|---|
| Check all that apply:<br>☐ Educational Assistant ☐ Classroom Volunteer ☐ Behviour Team/TOSA ☐ Peer Support | | |
| ☐ Technology Support | Please Describe: | |
| ☐ Modified Day/Schedule | Please Describe: | |
| ☐ Sensory/Environmental Adaptations | Please Describe: | |
| IPRC ☐ Yes ☐ No If yes, type of exceptionality: | | |
| IEP ☐ Yes ☐ No If yes, copy attached? ☐ Yes ☐ No | | |
| Behavioural Plan in place? ☐ Yes ☐ No If yes, copy attached? ☐ Yes ☐ No | | |
| Safety Plan in place? ☐ Yes ☐ No If yes, copy attached? ☐ Yes ☐ No | | |

| School Based Assessment/ Observations | | Copy of Assessment/ Observation Attached |
|---|---|---|
| ☐ Yes ☐ No Psychological | | ☐ Yes ☐ No |
| ☐ Yes ☐ No Academic | | ☐ Yes ☐ No |
| ☐ Yes ☐ No Speech and Language | | ☐ Yes ☐ No |
| ☐ Yes ☐ No Behaviour Resource Teacher | | ☐ Yes ☐ No |
| ☐ Yes ☐ No Occupational Therapy | | ☐ Yes ☐ No |
| ☐ Yes ☐ No Other Interventions/Services: | | ☐ Yes ☐ No |
| ☐ Yes ☐ No Other Interventions/Services: | | ☐ Yes ☐ No |

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Knowledge of access to Community Based Programs/Agency Involvement/Assessment/Diagnosis:

***School Contact Person***

*Signature:* ______________________ *Date: (Y/M/D)* __________

*Name:* ______________________

*(If signature cannot be provided, please type in name.)*

***Principal/Vice Principal***

*Signature:* ______________________ *Date: (Y/M/D)* __________

*Name:* ______________________

*(If signature cannot be provided, please type in name.)*

***Parent/Guardian Consent***

*I agree to have the above referral information released and exchanged between the School Board and SCIP/Wellkin for the purpose of accessing services.*

*Date: (Y/M/D)* __________

*Signature:* ______________________

*Name:* ______________________

*(If signature cannot be provided, please type in name and check the box below, indicating that verbal consent was provided.)*

☐ *Verbal Consent*