



## 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](mailto:SCIP@wellkin.ca) or fax: 519-539-7058

Date Referral Completed: \_\_\_\_\_

LDCSB  
 TVDSB

Oxford County  
 Elgin County

### Student Information

Name: _____	Address: _____
Date of Birth: _____ (Y/M/D)	(Including Postal Code) _____
Age: _____	_____
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Another Gender Identity	
Telephone #: _____	
Has <b>parent/guardian</b> given consent for SCIP to leave a message at this number? <input type="checkbox"/> Yes <input type="checkbox"/> No	

### School Information

Referring School: _____	Address: _____
Telephone #: _____	_____
Grade: _____	Class Size: _____
Principal: _____	
Teacher: _____	Teacher's Email: _____

#### Current and Past School Based Resources

<b>Psychology Services</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when? _____ Name: _____ Telephone #: _____ Email: _____	<b>Social Worker/School Support Counsellor</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when? _____ Name: _____ Telephone #: _____ Email: _____
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<b>Behavioural Services</b> <input type="checkbox"/> Yes <input type="checkbox"/> No Are they aware of this referral? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when? _____ Name: _____ Telephone #: _____ Email: _____	<b>LST/SPST</b> <input type="checkbox"/> Yes <input type="checkbox"/> No Are they the Primary contact person? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when? _____ Name: _____ Telephone #: _____ 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: <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Telephone #: _____	Email: _____
Has <b>parent/guardian</b> given consent for SCIP to leave a message at this number? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name: _____	Address: _____
Relationship: _____	(If different from child.) _____
Custodial Parent: <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Telephone #: _____	Email: _____
Has <b>parent/guardian</b> given consent for SCIP to leave a message at this number? <input type="checkbox"/> Yes <input type="checkbox"/> 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:  
 Educational Assistant    Classroom Volunteer    Behaviour Team/TOSA    Peer Support

<input type="checkbox"/> Technology Support	Please Describe:	
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<input type="checkbox"/> Modified Day/Schedule	Please Describe:	
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<input type="checkbox"/> Sensory/Environmental Adaptations	Please Describe:	
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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
<input type="checkbox"/> Yes <input type="checkbox"/> No   Psychological	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No   Academic	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No   Speech and Language	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No   Behaviour Resource Teacher	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No   Occupational Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No   Other Interventions/Services:	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No   Other Interventions/Services:	<input type="checkbox"/> Yes <input type="checkbox"/> No



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

**School Contact Person**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Name: \_\_\_\_\_  
*(If signature cannot be provided, please type in name.)*

**Principal/Vice Principal**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
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