School Community Intervention Partnership (SCIP)
School Referral Form

Prior to completing this referral form, please ensure you have:

- ✓ Completed the Pre-Referral Consultation with a Wellkin SCIP Consultant (see *SCIP School Referral Package Checklist)*; and
- ✓ Reviewed the eligibility and exclusionary criteria outlined on the *SCIP Criteria for Service* document, as well as the *SCIP School Referral Package Checklist* and have completed all of the required components.

Once all of the above requirements have been completed, please send this completed referral to the SCIP Team by email: SCIP@wellkin.ca or fax: 519-539-7058.

Pre-Referral Consultation Date*: _____	SCIP Consultant: _____
Date Referral Completed: _____	☐ LDCSB ☐ Oxford County ☐ TVDSB ☐ Elgin County ☐ Providence
Note: All Pre-Referral Consultations occur over the telephone, consist of sharing non-identifying student information only, and must occur within the same academic year as any SCIP School Referrals sent to Wellkin.	

Student Information

Name: _____	Address: _____
Date of Birth: (Y/M/D) _____	_____
Age: _____	
Telephone #:	Gender: ☐Male ☐ Female ☐ Another Gender Identity

School Information

Referring School: _____	Address: _____
Telephone #: _____	_____
Grade: _____	_____
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:

Document Updates July 28, 2023

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: (If different from child.)
Relationship:	
Custodial Parent: ☐Yes ☐No	
Telephone #:	Email:
Has **parent/guardian** given consent for SCIP to leave a message at this number? ☐Yes ☐No	
Name:	Address: (If different from child.)
Relationship:	
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. Please include/comment on academics, attendance, and social/peer relations. Please also include any strategies already implemented in an effort to support the child.

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		
☐ 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

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*