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's Central Intake (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.

Pre-Referral Consultation Date*: _____	Intake Therapist: _____
Date Referral Completed: _____	☐ LDCSB ☐ TVDSB ☐ Providence ☐ Oxford County ☐ Elgin County
Note: All Pre-Referral Consultations occur over the telephone, consist of sharing non-identifying student information only, must occur within the same academic year as any SCIP School Referrals sent to Wellkin, and occur with one school representative only. See the SCIP School Referral Package Checklist for more details.	

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 September 3, 2024

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. Please include/comment on academics, attendance, and social/peer relations. Please also include any strategies already implemented in an effort to support the child.

If you require additional space, please add on a separate document.

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:

If you require additional space, please add on a separate document.

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*