

## 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](mailto:SCIP@wellkin.ca).**

Pre-Referral Consultation Date*: _____	Intake Therapist: _____
Date Referral Completed: _____	<input type="checkbox"/> LDCSB <input type="checkbox"/> Oxford County <input type="checkbox"/> TVDSB <input type="checkbox"/> Elgin County <input type="checkbox"/> Providence
<p><b>*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.</b></p>	

### Student Information

Name: _____	Address: _____
Date of Birth: _____ (Y/M/D)	_____
Age: _____	_____
Telephone #: _____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Another Gender Identity

### School Information

Referring School: _____	Address: _____
Telephone #: _____	_____
Grade: _____	_____
Principal: _____	_____
Teacher: _____	Teacher's Email: _____
<b>Current and Past School Based Resources</b>	
<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: _____

## Parent/Guardian Information

Reason for Referral

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

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