

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 ☐ Oxford County ☐ TVDSB ☐ Elgin County ☐ Providence					
*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: \square Male \square Female \square 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 ☐ Yes ☐ No Support Counsellor					
If yes, when?		If yes, when?					
Name:		Name:					
Telephone #:		Telephone #:					
Email:		Email:					

Behavioural ☐ Yes ☐ No Services	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:							
Neiglionship.	(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 fo	or Referral							
Please provide details regarding the child's difficulties. social/peer relations. Please also include any strategies	Please include/comment on academics, attendance, and 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	d:						
Current	nd Doct Cla	2555000	Cupports				
	nd Past Cla	assroom	Supports				
Check all that apply: ☐ Educational Assistant ☐ Classroom Volunteer ☐ Behaviour Team/TOSA ☐ Peer Support							
			I I I I I I I I I I I I I I I I I I I	ет зиррогт			
☐ Technology Support	Please Describe:						
☐ Modified Day/Schedule	Please Describe:						
☐ Sensory/Environmental Adaptations	Please De	escribe:					
IPRC ☐ Yes ☐ No If yes, type of exception							
, . , ,	Yes 🗆 No						
Behavioural Plan in place?							
Safety Plan in place?							
School Based Assessment,	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/Assessr	nent/Diagnosis:			
School Contac	If you require additional space, please add on a separate documer	ιτ. -			
	i. Peisoii	Date:			
Signature:		- (Y/M/D)			
Name:	76	=			
	(If signature cannot be provided, please type in name.)				
Principal/Vice	r Principal				
Signature:		Date:			
Name:		(Y/M/D)			
	(If signature cannot be provided, please type in name.)				
Parent/Guard	lian Consent				
	e the above referral information released and exchanged between	Date:			
the School Bo	ard and SCIP/Wellkin for the purpose of accessing services.	(Y/M/D)			
Signature:					
		_			
Name:	(If signature connect he provided places type in name and cheek	_			
	(If signature cannot be provided, please type in name and check the box below, indicating that verbal consent was provided.)				
	☐ Verbal Consent				

T 1.519.539.0463 | TF 1.877.539.0463 | 912 Dundas Street, Woodstock, Ontario N4S 1H1 Elgin Office 3-80 Talbot Street, St Thomas, Ontario N5P 1E2 | WELLKIN.CA