

**Shared Referral Form for School Health Support Services and School Based Rehabilitation Services
Waterloo Region and Guelph-Wellington**

KidsAbility Centre for Child Development Fax to: 519-886-7292 Questions? Call: 519-886-8886 or 1-888-372-2259 x 1214	Waterloo Wellington Local Health Integration Network Fax to: 519-571-3961 Questions? Call: 519-883-5500 or 1-888-883-3313
Services Requested: KidsAbility *Occupational Therapy <input type="checkbox"/> *Physiotherapy <input type="checkbox"/> *Speech Therapy <input type="checkbox"/> Urgent equipment needs required for school entry (i.e. ramp, grab bars, mobility device)	Services Requested: WWLHIN Nursing <input type="checkbox"/> Personal Support <input type="checkbox"/> For Private School or Home-Schooled ONLY: WWLHIN *Occupational Therapy <input type="checkbox"/> *Physiotherapy <input type="checkbox"/> *Speech Therapy <input type="checkbox"/> Health Card Number (required):
<input type="checkbox"/> Request for service in French-if attending French school	<input type="checkbox"/> Request for service in French-if attending French school

*Supporting documentation must accompany referral

A. Child/Youth Demographics			
Surname:		First Name:	
Date of Birth (dd/mm/yy):		Gender:	
Address:		City:	Postal Code:
Parent/Guardian Name:			
Legal Guardian:	Y <input type="checkbox"/>	N <input type="checkbox"/>	Relationship:
Living With Child:	Y <input type="checkbox"/>	N <input type="checkbox"/>	
Address:	Same <input type="checkbox"/>	Other <input type="checkbox"/> (please include below)	
		City:	Postal Code:
Home Phone #:	Cell Phone #:		Work #:
Email:		Email Consent[^]: Y <input type="checkbox"/> N <input type="checkbox"/>	
Parent/Guardian Name:			
Legal Guardian:	Y <input type="checkbox"/>	N <input type="checkbox"/>	Relationship:
Living With Child:	Y <input type="checkbox"/>	N <input type="checkbox"/>	
Address:	Same <input type="checkbox"/>	Other <input type="checkbox"/> (please include below)	
		City:	Postal Code:
Home Phone #:	Cell Phone #:		Work #:
Email:		Email Consent[^]: Y <input type="checkbox"/> N <input type="checkbox"/>	
Custody Arrangements:			
Joint <input type="checkbox"/>	Sole <input type="checkbox"/>	No Agreement <input type="checkbox"/>	Formal Agreement <input type="checkbox"/>
Comments/Details:			

[^]Consent for use of email to receive handouts, letters, information about programs and events, and/or to schedule appointments. Consent can be withdrawn at any time. To opt out of specific types of communication, please indicate in the space provided.

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B. Additional Information:		
Language(s) Spoken:		Interpreter Required: Y <input type="checkbox"/> N <input type="checkbox"/>
Diagnosis (if any):		
Physician(s):		Phone Number:

C. Referral Source Information:		
School Board Name:	Other: Private <input type="checkbox"/> Home School <input type="checkbox"/>	
School:	City:	
Resource Teacher:	Classroom Teacher:	Grade:
School Principal:	Phone:	Fax:

D. Release of Information and Consent to Assessment:

I authorize KidsAbility and WWLHIN to collect, use and disclose relevant information regarding

_____ (client's name) to health professionals/agencies, institutions, or individuals involved for the purpose of prioritization, assessment for eligibility, service planning, treatment/care, and program evaluation of the School Health Support Services Program and/or School Based Rehabilitation Services. I authorize KidsAbility and WWLHIN to access information contained in the Ontario School Record if required. I understand I have the right to refuse or withdraw this consent at any time by providing written notice but the withdrawal of consent shall not have retroactive effect. I understand that refusal to provide consent may impact KidsAbility's and WWLHIN's ability to provide services. I understand no information is released for any other purposes, without my consent, unless required by law and that my consent is valid for as long as the above named is receiving School Health Support Services and/or School Based Rehabilitation Services. I understand it is my responsibility to inform any other guardian of this referral, that documentation may be requested in situations of joint/shared or sole custody and that information will be shared with both guardians upon request, unless documentation indicates otherwise.

Signature of Parent/Legal Guardian or Client (if 18 years or older)

Date

Signature of Principal/Designate

Date