SCHOOL BASED REHABILITATION SERVICES

Principal Referral Form

1240 Murphy Road Sarnia, ON N7S 2Y6
519-542-3471 TOLL FREE 1-855-542-3471 FAX 519-542-4115
www.pathwayscentre.org

☐ **Parent/Guardian has agreed to the school making this referral**

STUDENT INFORMATION:		
Name:	Date of Birth: (dd/mm/yyyy)	
Address: Postal Code:	Gender or Preferred pronouns: Language(s) spoken at home:	
Home Phone #:	Interpreter Required ☐ Yes ☐ No	
Does the student or family wish to identify as: ☐ First Nation ☐ Metis ☐ Inuit ☐ Other		
Confirmed Medical/Developmental Conditions:		

FAMILY IDENTIFICATION:	
Name:	Name:
Relationship to Student: ☐ Mother ☐ Father ☐ Guardian	Relationship to Student: ☐ Mother ☐ Father ☐ Guardian
Living with Child ☐ Yes ☐ No	Living with Child ☐ Yes ☐ No
Home Phone #:	Home Phone #:
Cell Phone #:	Cell Phone #:
Work Phone #: ext.	Work Phone #: ext.
Address: ☐ Same as above	Address: ☐ Same as above
Email Address:	Email Address:
☐ Special Circumstances/Custody Arrangements (required):	

SCHOOL INFORMATION:		
School:	Grade:	Classroom Number:
Learning Platform: ☐ In Person Learning ☐ Virtual Learning Program		
Principal:	Email: Ext.	
Resource Teacher:	Email: Ext.	
Classroom Teacher:	Email: Ext.	
Educational Assistant(s):		
Class Placement: ☐ Regular ☐ Modified Program ☐ Life Skills Program ☐ Other:		

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Student Name: _____ D.O.B. _____

Current School Interventions/Supports: ☐ IEP ☐ EA/DSW Support ☐ IPRC
☐ Student Receiving Resource Assistance ☐ Assistive Technology ☐ Enrichment
☐ High Needs Team/ABA Specialists ☐ Deaf and Hard of Hearing ☐ Blind-Low Vision
☐ Multi-disciplinary Student Support Team ☐ Collaborative Support Team ☐ Wellbeing Team
☐ Psycho Educational Assessment Completed: Date: Report Attached: ☐ Yes ☐ No

REFERRAL INFORMATION:

Assessment Requested: ☐ Occupational Therapy ☐ Physiotherapy ☐ Speech Therapy

Referral Initiated By: ☐ Teacher ☐ Parent ☐ School Board ☐ Psychologist
☐ SBRS Therapist (☐OT/☐PT/☐SLP) ☐ Other(specify):

Goal for student by making this referral?

PLEASE IDENTIFY THE COMPLETED FORMS/SUPPLEMENTARY INFORMATION INCLUDED WITH THIS REFERRAL:

☐ Teacher Checklist (**required** for Occupational Therapy and Physiotherapy referrals)

☐ Sample of Written Output **OR** Drawing/Colouring if not yet printing (**required** for OT fine motor & Assistive Technology referrals)

☐ School Board Speech Language Pathologist's Referral Form **OR** School Board Speech Language Pathologist's Report (**required** for all Speech Therapy referrals)

☐ Psycho Educational Assessment Report (**required** if available before referral)

☐ Other reports to support the need for assessment

☐ Applicable Individual Education Plan Goals

☐ Safety plan (if available)

Principal Signature: _____ Date: _____

Once completed please print and send by mail, courier or fax to:

Pathways Health Centre for Children
1240 Murphy Road, Sarnia, ON N7S 2Y6
Tel: (519) 542-3471
Toll Free: 1-855-542-3471
Fax: (519) 542-4115

For more information on referral process, please contact Tammy Holubeshen @ 519-542-3471 Ext.1284.