## INCLUSION OUTREACH

1031 Lucas Avenue Victoria, BC V8X 5L2 TEL: (250) 595-2088 FAX: (250) 592-5976

## REFERRAL UPDATE

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## I. STUDENT INFORMATION

PEN #				
Surname:	Given Name(s):			
Birthdate:	Gender:			
Home Address:				
Diagnosis:				Ministry Funding Category:
II. SCHOOL INFORMATION				
Key Contact Person & Position:			Email:	
Name of School:	Classroom Placement	Phone:		
School Address:			Fax:	
Teacher:	Teaching Assistant(s):			
Principal:	School Hours (e.g., 8:40 – 12:00; 1:00 – 3:00)			
School District Name and No:				
Director of Special Education:	District Partner:			
III. PARENT/GUARDIAN INFORMAT	ION			
Parent/Guardian Name & Address, Postal Code:			Phone (Home) :	
Email:			Phone (Work) :	
Foster Parent/Associate Family Name & Address, Postal Code:			Phone (Home):	
Email:			Phone (Work):	
MCF Social Worker Name & Address:			Phone:	
Email:			Fax:	
IV. SIGNATURES				
Parent:	District Partner:			
Principal:	District Admin:			
Please note: Cost for release time for team meetings for teacher(s),	teaching assistant(s) and district	support staff is covered by th	ne student's dist	rict

Birthdate:Signature:Signature:Signature: Thisday of20 (valid for a period of three years from this date)			
			ETE MAILING ADDRESS
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**NOTE:** Applicable Release of Authorization forms for Hospitals will be forwarded by mail/fax (e.g., Queen Alexandra Centre for Children's Health, Children's & Women's Health Centre of British Columbia (Sunny Hill), B.C. Children's Hospital, Alberta Children's Hospital).

Please outline with as much detail as possible, what you would like to receive from the Inclusion Outreach team, which questions you would like answered and specific problems or areas of concern your team members may have.