INCLUSION OUTREACH

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

REFERRAL FORM

Program Coordinator: Christopher J. Jenkins, Ph.D.
cjenkins@sd61.bc.ca

I. STUDENT INFORMATION

PEN #

Surname:	Given Name(s):	Birthdate:
Home Address:		Referral Date:

• Have you done a MAPS for the student or any other long-term goal setting?

Yes______ No_______

Gender:	
Diagnosis:	Ministry Funding Category:

II. SCHOOL INFORMATION

Case Manager email address:

Key Contact Person & Position:		Phone:
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.:		Phone:
Director of Special Education:	District Partner:	

III. PARENT/GUARDIAN INFORMATION

Parent/Guardian Name & Address, Postal Code: Email Address:	Phone (Home): Phone (Work):
Foster Parent/Associate Family Name & Address, Postal Code: Email Address:	Phone (Home): Phone (Work):
MCF Social Worker Name & Address, Postal Code: Email Address:	Phone:

Has this student been referred to and/or received services from other Provincial Outreach Programs?

- ☐ SET-BC
- ☐ Provincial Outreach Program for Students with Deaf/Blindness
- ☐ Provincial Outreach Program for Autism & Related Disorders
- ☐ Jericho Outreach Program
- ☐ Vision Outreach Program
- ☐ Other

Please specify:

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 the student's district

STUDENT STATUS

1. *Positioning/Mobility*

   How does the student move around in school and at home?

   ☐ *Manual Wheelchair* ☐ *Power Wheelchair* ☐ *Walker* ☐ *Ambulatory*

   What are the different positions the student uses in the classroom and at school?

   ☐ *Standing Frame* ☐ *Sidelyer*

   ☐ *Other (please elaborate)*

2. *Fine Motor / Gross Motor Coordination– is the student CURRENTLY using fine/gross motor skills in one or more of the following?*

   ☐ *Switch Activities (specify) (e.g. Powerlink)* ____________________

   ☐ *School Activities (specify)* ____________________

   ☐ *Rec/Leisure Activities (specify)* ____________________

   ☐ *Self Care Activities (specify)* ____________________

3. *Sensory Impairment – Has the student been identified as having a sensory impairment?*

   ☐ *Visual* ☐ *Hearing* ☐ *Other*

   Please elaborate on extent of sensory impairment: ____________________

4. *Communication Skills*

   (a) What is the student's CURRENT level of communication?

   ☐ *Speaking* ☐ *Non-speaking* ☐ *Speech Difficulty (please comment)* ____________________

   (b) If the student uses augmentative/alternative communication systems, please indicate the student's primary mode of communication.

   ☐ *Sign Language* ____________________

   ☐ *Non-Formalized Communication System* ____________________
   (e.g. gestures, facial expression)

   ☐ *Non-Technical Aids (specify type e.g. communication board, object choices, pictures choices)*

   ☐ *Technical aids (specify type e.g. BIGmack)* ____________________

   (c) Receptive understanding of language – Does the student demonstrate by his/her actions:

   ☐ *Simple routine commands* ☐ *Simple routine questions*

   Please elaborate: ____________________

   ____

5. *Activities of daily living – Student needs assistance with*

   ☐ *Eating* ☐ *Dressing* ☐ *Toileting* ☐ *Safety*

6. *Please provide us with any information on the student's current health requirements which could be of assistance to us in providing services (e.g. seizure activity, timed medication, special rest periods, gastrostomy tube, level of care for the student).*

   ____

   ____

• Please attach IEP including date and people involved

VIDEO OF STUDENT

Please also submit a video of your student with this referral form.
The video should be under 10 minutes and include the areas listed below.

1. ☐ The student moving down the hallway and entering his/her classroom (Independent mobility if possible).
2. ☐ The student sitting in his/her usual classroom chair.
3. ☐ Close-up of the student's face during an activity (e.g., looking at a storybook).
4. ☐ A close-up of the student using any equipment (e.g. communication, positioning and adaptive).
5. ☐ The student demonstrating an activity which requires hand use (e.g. switch use, reaching and grasping, etc.).
6. ☐ A structured classroom activity involving the student (e.g. choice making).
7. ☐ The student involved in one-to-one conversation.
8. ☐ The student involved in his/her favorite activity.
9. ☐ The student involved in an eating activity.
10. ☐ The student engaged in communication (e.g. pointing, sign language, choice making).

NOTE: ◆ Note that it is the school's responsibility to obtain parental permission before making the video

PARENTAL CONSENT FOR VIDEO OF STUDENT

I request that the video of my child be released to Inclusion Outreach in order to assist them in evaluating this referral.

I understand that this video will be kept by Inclusion Outreach and will not be released without my permission.

Student's Name: ______________________________ Birthdate: ____________________
Date(s) video taken:____

Teacher (please print): __________________________ Signature: ____________________

Parent/Guardian (please print): ____________________ Signature: ____________________

Witness (please print): __________________________ Signature: ____________________

Signed at (location): ___________________________

This ________ day of _______________________20___

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Inclusion Outreach to exchange information with necessary contacts regarding my child. I also waive any and all claims against program staff for all purposes whatsoever arising from the disclosure of information contained in the records.

Name of Student:________________________________	Birthdate:____________________________________
Parent/Guardian (please print): ____________________	Signature:____________________________________
Witness (please print): __________________________	Signature:____________________________________
Signed at (location):____________________________	This _________day of____________________________20______ (valid for a period of three years from this date)

SUPPORT SERVICES RECEIVED FROM SCHOOL DISTRICT

NAME	PHONE	FAX	EMAIL (if applicable)	COMPLETE MAILING ADDRESS
District Occupational Therapist				
District Physiotherapist				
District Speech/Language Pathologist				
District Teacher of the Deaf & Hard of Hearing				
District Teacher of the Visually Impaired				
Other				

NOTE: Applicable Release of Authorization forms for Hospitals will be forwarded by mail. (e.g., Queen Alexandra Centre for Children's Health, Children’s & Women’s Health Centre of British Columbia (SunnyHill), B.C. Children's Hospital, Alberta Children's Hospital).

INCLUSION OUTREACH REFERRAL FORM

Please return completed referral package to:

Inclusion Outreach
1031 Lucas Avenue •Victoria, BC. • V8X 5L2 • Tel: (250) 595-2088 Fax: (250) 592-5976

INCLUSION OUTREACH REFERRAL FORM

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.