

Referral Form

{inclusion outreach}

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Please fax Inclusion Outreach or email completed form to: mstark@sd61.bc.ca

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Victoria, BC V8X 5L2
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Fax 250-592-5976
www.inclusionoutreach.ca

1. STUDENT INFORMATION

Surname, First Names:	Birthdate:
Gender Identity:	PEN#:
Diagnosis:	Ministry Funding Category:

2. SCHOOL INFORMATION

Case Manager:	Email:
School:	Address:
Telephone:	Grade:
Principal – Name and Email:	School District:
Teacher – Name and Email:	Educational Assistant – Name and Email:
Principal Signature:	District Partner – Name and Email:
District Administrator Signature:	District Partner Signature:

Please note: Cost for release time for team meetings for teacher(s), educational assistant(s) and district support staff is to be covered by the student's district.

3. REFERRAL PROCESS

In addition to completion of this Referral Form, please include:

- ☐ Consent forms (Standard consent and Student Website Consent)
- ☐ A short video of the student including examples of mobility, communication, classroom inclusion and mealtime (*school is responsible for obtaining appropriate parental permissions*).
- ☐ A copy of the student's most recent IEP.
- ☐ Detailed outline of questions you would like answered and ways we can best support you.
- ☐ Any relevant reports (medical, SLP, PT, OT, etc.) contained within the student's school file.

Submit the Referral Form, Consent Forms, requested documents and video to your District Partner for forwarding to Inclusion Outreach. Upon acceptance, parents/guardians, the school Case Manager and your District Partner will be notified by email.

4. STUDENT STATUS

<p>Has the student been referred to and/or received services from:</p> <p><input type="checkbox"/> SET-BC</p> <p><input type="checkbox"/> Deaf/Blindness Provincial Outreach Program (POPDB)</p> <p><input type="checkbox"/> Autism & Related Disorders Provincial Outreach Program (POPARD)</p> <p><input type="checkbox"/> Provincial Resource Centre for the Visually Impaired (PRCVI)</p> <p><input type="checkbox"/> Other</p>
<p>Has the student been identified as having a sensory disorder?</p> <p><input type="checkbox"/> Vision</p> <p><input type="checkbox"/> Hearing</p> <p><input type="checkbox"/> Other</p>
<p>Please provide us with any information on the student's current health status:</p>

5. DISTRICT SUPPORT SERVICES

Occupational Therapist	Phone	Email
Physiotherapist	Phone	Email
Speech Language Pathologist	Phone	Email
Teacher of the Deaf and Hard of Hearing	Phone	Email
Teacher of the Visually Impaired	Phone	Email
Other	Phone	Email

6. Questions you would like answered and ways our team can best support you: