Referral Form {inclusion outreach}

1031 Lucas Avenue

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[www.inclusionoutreach.ca](http://www.inclusionoutreach.ca/)

1. **STUDENT INFORMATION**

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

1. **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.***

1. **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 medical reports 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.

1. **STUDENT STATUS**

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

1. **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 |

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