DISTRICT STUDENT SUPPORT SERVICES REFERRAL

2557 Beverly Street, Duncan, BC, V9L 2X3 Tel: (250)748-4511 Fax: (250)748-4617



ST	STUDENT INFORMATION						
Student:		DOB:	Date:				
Essalling Teachess		DEM.	Condo				
Enrolling Teacher:		PEN:	Grade:				
Parent(s)/Guardian(s):		School:					
RE	FERRAL IN	FORMATION					
School Based Team (SBT) Members:			Date:				
Reason:							
Intervention(s) 1.			Date:				
Already Tried: 2.			Date:				
3.			Date:				
Case Manager:		*Please attach SBT Meeting M	linutes.				
		ck all applicable services require					
District Elementary Counsellor *		tinerant Resource Teacher: Visu					
District Speech and Language Pathologist *			f and Hard of Hearing Services *				
Occupational Therapist	☐ District I	District Itinerant Resource Teacher: Hospital/Homebound Services					
District School Psychologist *	☐ District I	tinerant Resource Teacher: Inte	gration Support Services *				
☐ Physiotherapist	* Please atta	ch completed additional service	specific checklist.				
Signatures:							
Referring Teacher	Learnin	g Assistance Teacher	Principal				
INFORMED CONSENT		Please Initial: AGREE _	DO NOT AGREE				
Informed consent is the result of a process of reaching ar							
form signed. In obtaining informed consent, parents and	l guardians sh	ould be provided with as much i	information as a reasonable or				
prudent person would want to know before making a decision or consenting to a School District assessment process, procedure, or service.							
Reasonable steps should be taken to ensure that all the ap			ent or guardian in a manner to ensure				
that they clearly understand what they are consenting to	on behalf of t						
PARENT CONSENT	1 1.1 1	Please Initial: AGREE _	DO NOT AGREE				
I give permission for Student Support Services staff to w							
for home application arise, then I expect to be consulted.							
the teacher (and other District Staff as appropriate) so the							
that I will be actively involved in decisions regarding spo	-	Please Initial: AGREE	DO NOT AGREE				
When a parent gives consent for services they are also giving permission for the specialist to access all relevant documents concerning the referred student and to speak with other School District professionals who have been involved with the student. This consent to access							
confidential information may be revoked by the parent at any time. When the assessment is completed, the consent will automatically be							
revoked. The information collected on this form (authority: School Act (section 13 and 97) will be protected under the Freedom of							
<u>Information and Protection of Privacy Act</u> . The information will be shared for education program purposes and if legally required by							
section 97 (2) of the School Act, may be provided to health services or other support services. Questions about the collection and use of							
this information should be directed to the principal of your school.							
ACKNOWLEDGEMENT AND CONSENT							
I, acknowledge that I have read and understood the information above.							
AGREE		DO NO	OT AGREE				
I (we) have read the information above and <u>consent</u> to ha	ave the		on above. I (we) do not consent to				
service(s) indicated performed with my (our) child.		have the service(s) indicated performed with my (our) child.					
Signature of Parent or Legal Guardian	Date	Signature of Parent or L	egal Guardian Date				

REFERRAL FOR DISTRICT SUPPORT SERVICES



SPEECH-LANGUAGE PATHOLOGIST REFERRAL QUESTIONNAIRE

Person filling out this form:

Does	the	ctud	ont.

D_0	es the student.		
1.	Have speech/voice quality that is difficult to understand?	Yes:	No:
2.	Repeat words or parts of words/get "stuck" or "stutter"?	Yes:	No:
3.	Expressive Language a) able to carry on a conversation? b) use grammatically correct sentences? c) able to describe events? d) use limited vocabulary?	Yes: Yes: Yes: Yes: Yes:	No:
4.	Have difficulty following spoken directions?	Yes:	No:
5.	Have trouble "paying attention" or making eye contact?	Yes:	No:
6.	Have problems with play/interactions?	Yes:	No:
7.	Have medical history/professional (private SLP) involved? Please circle: PT/OT/SLP/Pediatrician/other:	Yes:	No:
8.	Have a recent hearing and/or vision evaluation? Date if known:	Yes:	No:
9:	Other:		

This questionnaire will help guide the Speech-Language Pathologist in assessing the student's speech-language abilities. Thank you for answering these important questions.