|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Occupational Therapy (OT) Services** | | **Physiotherapy (PT) Services** | | | |
| **\*\*The OT or PT has reviewed this referral \_\_\_\_\_\_\_\_\_\_\_ (therapist initials)** ****Referral Guidelines:****  * Review student file for previous OT or PT recommendations that are still applicable. * Speak with OT or PT prior to referral to ensure it is an appropriate request. * Ensure School Based Team is aware of referral. * Write specific details about the Reason for Referral See next page for sample reasons for referral. * If you have any queries regarding possible medical/neurological/other impairments affecting a student’s function, please consult with your school’s OT or PT **before** making a referral. | | | | | |
| Student Name: |  | | Gender: | Male | Female |
|  | Last, First | | DOB: |  | |
| Also Known As: |  | |  | Month/Day/Year | |
| Care Card No. |  | |  |  | |
| School: |  | | Grade: |  | |
| School Contact: |  | | Teacher: |  | |

**Specific Functional Reason for Referral:**

**Consent for Referral**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, am the parent or legal guardian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. **My signature below indicates consent for the OT and/or PT assigned to provide consultation regarding my child and verifies the Contact Information on the following page**. These services have been discussed with me by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

I understand that The Greater Victoria School District (SD61) contracts Occupational Therapy and Physiotherapy services from the Queen Alexandra Centre for Children’s Health (QACCH) of Island Health (VIHA). Reports related to OT and/or PT will be filed with the QACCH and SD61. I will receive a copy of all reports by OT and/or PT. A copy of report(s) written by the OT and/or PT will also be sent to the school principal and placed in the student’s file. The school’s copy of the report will be accessible only to authorized school personnel providing educational services to the student.

Please note, you may contacted by QACCH intake to confirm the information on this referral. Your child’s school therapist(s) will also need to be in contact with you prior to initiating service.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature Date: (Month/Day/Year)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School Administrator Signature Date: (Month/Day/Year)

**Parent/Legal Guardian Contact Information #1:**

|  |  |  |  |
| --- | --- | --- | --- |
| Parent/Guardian: |  | Home #: |  |
| Relationship: |  | Cell #: |  |
| Address: |  | Work #: |  |
| Postal Code: |  | E-mail: |  |
| Preferred method of contact: 🞏 Home Phone 🞏 Cell Phone 🞏 Work Phone  Please note, due to privacy policies to protect confidentiality,  we are limited in what can communicate through email. | | | |

**Parent/Legal Guardian Contact Information #2:**

|  |  |  |  |
| --- | --- | --- | --- |
| Parent/Guardian: |  | Home #: |  |
| Relationship: |  | Cell #: |  |
| Address: |  | Work #: |  |
| Postal Code: |  | E-mail: |  |
| Preferred method of contact: 🞏 Home Phone 🞏 Cell Phone 🞏 Work Phone  Please note, due to privacy policies to protect confidentiality,  we are limited in what can communicate through email. | | | |

**Sample Reasons For Referral For OT and/or PT Services:**

Diagnosis alone, e.g., Down Syndrome or Cerebral Palsy, is NOT a sufficient reason for a referral. Please review previous recommendations made by the OT or PT before making a referral, and then give practical reasons for the therapist to become involved.

* What do you want the student to **do**?
* How do you want the student to **participate** differently?

**OT: Please help the student to**:

* **Access** the school environment **safely** for daily functioning (ie. equipment needs, safe transfers)
* Participate in self-care tasks more independently (ie. toileting, dressing, feeding)
* Transition to adult services i.e. Community Living BC (CLBC) from pediatric services
* Transition to a new school environment for students with complex conditions
* Participate in school and/or community activities, where motor coordination or sensory processing may be a barrier

**PT: Students who need help with:**

* Using a walker, wheelchair, standing frame, and/or braces safely and correctly (with the exception of a simple bone fracture on a typically developing child)
* Being safely and correctly lifted or moved in and out of specialized equipment (list the equipment on the first page of the referral form)
* Alternate positioning and/or range of motion program to prevent pressure sores, or joint range of motion restrictions
* High risk of falls or there is concern around safety with functional mobility (e.g. stairs) due to physical limitations.
* Ongoing monitoring of physical status and mobility due to a progressive deteriorating condition or are at high risk for hip dislocation.
* Range of motion and/or strengthening exercises to maintain functional mobility.
* Being unable to participate/be included in P.E., playground time and other physical activities throughout the school day, due to physical limitations (where behaviour, attention, or sensory concerns are not the underlying cause of lack of participation)