



School Age Therapy (OT/PT) Referral 61/62/63
Please fax referral form to Island Health at 250-519-6918

- This form is for the School Based Team to share functional concerns they are noticing about a student at school.
- **Completing this form does not guarantee Occupational Therapy (OT) or Physiotherapy (PT) services.**
- Island Health Clinical Intake reviews the information and makes eligibility decisions.
- Referral data is tracked to support equitable access and consistency in decision-making.
- Referrals should include sufficient information for screening. Where further clarification is required, the screener will contact the school team to schedule a follow-up conversation.

Before Making a referral:

- ☐ Review exclusion criteria below. If exclusion criteria are met, please redirect to more appropriate service:
 - ☐ Concern primarily behavioral / mental health / trauma
 - ☐ Executive functioning or attention only concerns
 - ☐ Writing concerns without other motor concerns
 - ☐ Isolated short-term injury in a typically developing child
 - ☐ Selective eating without safety risk
- ☐ Review student file for previous OT or PT recommendations that may still be applicable.
- ☐ Implement appropriate Universal Supports for Learning strategies.

- ☐ Obtain guardian consent for QA School Age Program eligibility screening

Name of consenting guardian _____ Date consent obtained _____

- ☐ Review this eligibility screening with School Administrator

Name of consenting Administrator _____ Date consent obtained _____

Student Name:	_____	Sex at Birth:	☐ Male	☐ Female
	Last, First		☐ Intersex	
Also Known As:	_____	Pronouns:	_____	
Care Card No.	_____	DOB:	_____	
School:	_____	District:	Month/Day/Year	
Referring person:	_____	Grade:	_____	
	_____	Teacher:	_____	

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 ☐ 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 ☐ Email**	

****Due to confidentiality, we are limited in what we can send via email.**

FUNCTIONAL IMPACT (check all that apply)**School Participation**

- ☐ Difficulty with classroom motor tasks
- ☐ Difficulty with transitions or routines after using universal supports
- ☐ Challenges with PE inclusion or playground participation
- ☐ Difficulties exist across multiple environments (home, school, community)

What does this look like at school?

Self-Care

- ☐ Swallowing concerns (choking or aspiration)
- ☐ Dressing
- ☐ Toileting
- ☐ Self Feeding

What does this look like at school?

Mobility & Access

- ☐ Risk of falls or frequent falling
- ☐ Requires lifts or transfers
- ☐ Difficulty moving safely around school
- ☐ Challenges with seating or positioning
- ☐ Difficulty accessing classroom or school environment

What does this look like at school?

Other

- ☐ Transition to adulthood support for children with medical complexity

Universal Strategies and Equipment currently in use

What does this look like at school?

Are any staff members assigned to supporting this student? ☐ Yes ☐ No

If yes, who? _____ Position type: _____

Anything else you want us to know?

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Island Health use only	Eligibility outcome	ACCEPT	☐	DECLINE	☐
Reason for decline:					
☐ Concern primarily behavioral / mental health / trauma		☐ Writing concerns without motor involvement			
☐ Executive functioning or attention only concerns		☐ Selective eating without safety risk			
☐ Isolated short-term injury in a typically developing child					