Ref ID # _____

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

NAME: _____ REF ID # _____

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?

NAME: _____ REF ID # _____

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?

Please fax referral form to Island Health School Age Program at 250-519-6918

Island Health use only Eligibility outcome ***ACCEPT*** ***DECLINE***

Reason for decline:

- ☐ Concern primarily behavioral / mental health / trauma
- ☐ Executive functioning or attention only concerns
- ☐ Isolated short-term injury in a typically developing child
- ☐ Writing concerns without motor involvement
- ☐ Selective eating without safety risk