[ ]  **Parent/guardian has agreed to this referral (this box must be checked)** [ ]  **RE-REFERRAL**

|  |
| --- |
| **STUDENT INFORMATION** |
| Student’s Name:  |       | Date of Birth: |       |
|  |  (Last, First, Initial) |  |

|  |
| --- |
| (Month/Day/Year) |

 |
| Gender: [ ]  Male [ ]  Female [ ]  Gender Neutral |
| **CAREGIVER INFORMATION** |
| **Primary Contact**: |       | Relationship to Client: |       |
|  Address: |       |  City: |       | Postal Code: |       |
| Home Telephone: |       | Cell Phone: |       | Work Phone: |       |
| E-mail: |       |  |  |
| **Secondary Contact**: |       | Relationship to Client: |       |
|  Address*(if different than above)*: |       |  City: |       | Postal Code: |       |
| Home Telephone: |       | Cell Phone: |       | Work Phone: |       |
| E-mail: |       |  |  |
| Student Lives With: [ ]  Parents [ ] Mother [ ]  Father [ ]  Other:  |       |
| Language(s) Spoken:  |       | Interpreter Required: [ ] Yes [ ] No  |
|  |  |
| **SCHOOL INFORMATION** |
| School: |       |
| Address: |       | City: |       | Postal Code: |       |
| Phone: |       | Fax: |       |
| Principal: |       | Signature: |  |
|  |  |  |  ***(Signature required for school initiated requests)*** |
| Teacher: |       | Grade: |       |  IEP: [ ] Yes [ ] No |
| Class Placement: [ ]  Regular [ ]  Special Education Support [ ]  Special Education Class |
| Person to contact at school for further information: |       |
|  |  |
| **REASON FOR REFERRAL** |
| Services Requested: | [ ]  Occupational Therapy ***(OT approval required):*** |  |
|  |  |  **(OT Signature)** |
|  | [ ]  Physiotherapy: [ ]  participation [ ]  mobility [ ]  safety |
|  | [ ]  Speech-Language Pathology *(SLP referral required)*  |
| **COMMENTS:**       |
| Referral Initiated By: |       | Signature: |       |
| School Board/Agency: |       | Date: |       |

|  |
| --- |
| **PLEASE FAX COMPLETED FORM TO JMCC AT FAX NUMBER: 519.252.5873** |