REQUEST FOR SERVICE: NORTH VANCOUVER SCHOOL DISTRICT #44

North Shore School Occupational Therapy (NSSOT) Program

2805 Kingsway, Vancouver, BC V5R 5H9
Tel: 604.451.5511 Fax: 604.451.5651 Web: www.bc-cfa.org

Request Checklist

I have included the following information or documents to this referral:

- ☐ Student's designation (if applicable)
- ☐ Observation notes
- ☐ Fine motor screen
- ☐ Information on Private OT services, if there has been private OT

Please confirm that the consent form has been carefully completed including:

- ☐ Parent/Guardian signature
- ☐ Witness signature
- ☐ Initials beside any relevant service providers for this student
- ☐ Initials beside "other BCCFA programs" (first line) if the student was previously seen by Early Intervention Therapy or other programs.
- ☐ Initials beside Private Therapists (if applicable) and the names of any private service providers

If this student has an IEP, it is attached and includes a goal specifically related to this OT request.	Yes ☐ No ☐ N/A ☐
If this student has received a psych ed. assessment, it is attached.	Yes ☐ No ☐ N/A ☐
If this student has gross motor concerns, referral to physiotherapy services has been discussed with the family and school based team.	Yes ☐ No ☐ N/A ☐

For those students who do not have a low incidence designation:	
Psych-ed testing has identified fine motor concerns:	Yes ☐ No ☐ N/A ☐
A fine motor screener has been completed and is attached:	Yes ☐ No ☐ N/A ☐

Please be aware that if a student has transferred from another district, referral to the school Occupational Therapy program should be discussed at a school based team meeting level. Please determine if needs can be met at a school based level or if the OT referral should be placed on the SD44 waitlist based on the original date of referral.

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Section 1 - Student and Parent Information (PLEASE PRINT)

STUDENT'S FIRST NAME	STUDENT'S LAST NAME	MSP PERSONAL HEALTH NUMBER

DATE OF BIRTH (DD/MM/YYYY)	STUDENT'S GENDER ☐ Male ☐ Female	STUDENT RESIDES WITH ☐ Both Parents ☐ Mother only ☐ Father Only ☐ Foster Family ☐ Other

NAME OF PARENT(S) OR Legal GUARDIAN (FIRST AND LAST)

Mother(s): Father(s): Other Guardian:

ADDRESS (where student resides)	CITY	POSTAL CODE

TELEPHONE	WORK/MOBILE	EMAIL

THE LEGAL GUARDIAN FOR THIS STUDENT IS:

☐ Both Parents ☐ Mother only ☐ Father Only ☐ MCFD SW ____________________________ ☐ Other ____________________________

name please specify

If applicable – please provide a copy of any legal custody document regarding this student.

Language spoken in home? ____ Is English Understood? ☐ Yes ☐ No

Do you self-identify with any Aboriginal or First Nations group? ☐ Yes ☐ No

Section 2 - School Information (PLEASE PRINT)

SCHOOL NAME	GRADE	☐ LEARNING SUPPORT TEACHER or ☐ CASE MANAGER
TEACHER	SPECIAL EDUCATION ASSISTANT	SPEECH LANGUAGE PATHOLOGIST

Section 3 - Reason(s) for Referral

Please indicate area(s) of concern: ☐ Equipment needs ☐ Self-care ☐ Self-regulation ☐ Fine motor/written output

Primary Concerns of School (Please describe the impact on learning/school participation. Be specific):

Primary Concerns of Family (Please describe the impact on learning/school participation. Be specific):

Section 4 - Pertinent Medical History

Does this student have a low incidence designation? Yes ☐ No ☐ Pending ☐

If yes or pending, please check designation: A ☐ B ☐ C ☐ D ☐ E ☐ F ☐ G ☐ H ☐

Please specify medical diagnosis If no medical diagnosis, please ensure there is some assessment information indicated below.

Agencies or Specialists Involved: e.g.: Sunny Hill Health Centre, BC Children's Hospital, North Shore Health Region, Orthopaedic Surgeon, Neurologist etc

Previously:____

Current:____

Assessment date(s) and findings:______________________________

Section 5 (MUST BE COMPLETED)

Date of Referral: ____________________

Referred By: ____________________
(school district representative)

By signing this form, I indicate my agreement with this referral to Occupational Therapy. I have completed the Consent to Obtain/Release Information form.

Signature of Parent/Guardian: ______________________________

Signature of NVSD #44 District Administrator: ______________________________

Instructions for school staff:

All referrals must be reviewed by the School-Based Team and signed by parents prior to forwarding to Learning Services. Please attach Consent form initialed and signed by parent/guardian plus initialed Rights and Responsibilities form. Once the referral has been processed by Learning Services, the information will be forwarded directly to BC Center for Ability.

CONSENT TO OBTAIN/RELEASE INFORMATION
North Shore School Occupational Therapy Program

2805 Kingsway, Vancouver, BC V5R 5H9
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NVSD and WVSD contract with BC Centre for Ability to deliver school-age Occupational Therapy consultation services. In order to provide safe and effective services, OTs need to request information from and share information with your child's other service providers, verbally and in writing. All information is treated as strictly confidential. A copy of this consent will be sent to all persons/agencies when written information is requested from them. All program reports will be sent to parent(s) and/or guardian in addition to the school team.

______________________________ ______________________________

Student's Name (First and Last names) **Student's Date of Birth (mm/dd/yy)**

I, the undersigned, do hereby authorize the BC Centre for Ability to obtain and/or release medical and educational information regarding my above named child from the persons/agencies listed below.

Obtain From	Release To	Name of Person/Agency
Example *AW*	Example *AW*	Please enter your first and last initials in the boxes beside the persons/agencies you authorize us to obtain information from and/or to release information to. PLEASE DO NOT CHECK THE BOXES, WE NEED YOUR INITIALS.
		Other BCCFA programs including: Early Intervention Therapy, Community Brain Injury for Children and Youth, Stepping Stones and adult programs
		Health Authority including school-age physiotherapy and nursing support services
		Supported Child Development Programs / after school daycare
		BC Children's Hospital, Sunny Hill Health Centre for Children. Other hospital:
		Foster Parent(s)
		Ministry of Child & Family Development including CYSN, At Home & Autism Funding
		Community Living BC
		Behaviour Consultant/Team (please name):
		Group Home staff (please identify home):
		Private Therapists (please list first & last names):
		My Child's doctor(s) (please list first & last names):
		Other:

I consent to BCCFA staff obtaining information from/releasing information to school staff and understand that this is essential for delivery of services within this program.

______________________________ X______________________________ ______________________

Custodial Parent/Legal Guardian Printed Name **Custodial Parent/Legal Guardian Signature** **Relationship to Child**

______________________________ X______________________________ ______________________

Date
(Consent expires one year from this date)

Witness Signature
(Must be at least 18 years old)

Witness Printed Name

Your Rights

The Right to Information

You have the right to:

- receive copies of all reports written by the North Shore School Occupational Therapy Program about your child.
- see your child's health record at the Centre at any time by contacting the Program Director. (Please note: In keeping with the *Freedom of Information and Protection of Privacy Act*, the Centre does not make copies of reports originating from other agencies).
- complete and unbiased information about assessment, intervention, and service options.
- ask questions and receive answers regarding your child's assessment and any aspect of your child's intervention.
- receive verbal information from therapists in a language that you understand. The Centre will provide interpretation services to families and children to support home based services when necessary.
- information about community resources that may be suitable and available for your child and your family.

The Right to Confidentiality

- All staff, volunteers and students at the BC Centre for Ability sign a Confidentiality Agreement when they are hired. Breaches of confidentiality are grounds for discipline by the Centre as well as by professional colleges or registering bodies.
- Information about your child or your family will not be released without your written consent.

The Right to Refuse Services

- OTs will explain any service or intervention they propose or recommend including any potential risks. You have the right to refuse any service or intervention you believe is not in the best interests of your child or family.

The Right to Provide Feedback

- You have the right to express concerns or complain about your services. A complaint will not result in the loss of services. Compliments are also welcome. To provide feedback please call the Program Director at 604-630-3001

Your Responsibilities

- Please inform staff as soon as possible if your child has an OT appointment which he/she is unable to keep.
- Please inform staff who are scheduled to visit your home, if you or your child is sick.
- Please inform staff if your child is also working with an Occupational Therapist in private practice. It may be necessary to prepare a co-therapy agreement.
- Please let us know if you need clarification about the nature of this consultation service.

Please sign below to confirm that you have been given information about your rights and responsibilities.

Initial: ______________________ **Date:** ______________________