KidsAbility™

APPLICATION FOR SCHOOL BASED REHABLITIATION SERVICES
PARTNERING FOR CHANGE (P4C) OCCUPATIONAL THERAPY (OT) NEW REFERRAL

Student Surname: **First Name:**
Date of Birth: **Gender:**

A. Student Demographics		
Address:	**City:**	**Postal Code:**
Parent/Guardian Name:		
Legal Guardian: Y ☐ N ☐ **Living With Child: Y ☐ N ☐**	**Relationship:**	
Address: ☐ Same	**City:**	**Postal Code:**
Home Phone Number:	**Cell Phone Number:**	**Work Number:**
Email:	**Email Consent: Y ☐ N ☐**	
Parent/Guardian Name:		
Legal Guardian: Y ☐ N ☐ **Living With Child: Y ☐ N ☐**	**Relationship:**	
Address: ☐ Same	**City:**	**Postal Code:**
Home Phone Number:	**Cell Phone Number:**	**Work Number:**
Email:	**Email Consent: Y ☐ N ☐**	
Custody Arrangements: **Joint ☐ Sole ☐ No Agreement ☐ Formal Agreement ☐** **Comments/Details:**		

B. Additional Information:		
Language(s) Spoken:		**Interpreter Required: Y ☐ N ☐**
Diagnosis (if any):		
Physician(s):		**Phone Number:**

C. Referral Source Information:		
School Board Name:	**Other: Private ☐ Home School ☐**	
School:	**City:**	
Resource Teacher:	**Classroom Teacher:**	**Grade:**
School Principal:	**Phone Number:**	**Fax:**

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D. Reason for referral (To be completed by referring P4C OT)			
IDENTIFY THE STUDENT'S AREAS OF DIFFICULTIES REQUIRING DIRECT OT INTERVENTION:			
1	**Self-care**	**Main concerns:**	
2	**Productivity**	**Main Concern:**	
3	**Leisure/sports**	**Main Concerns:**	
4	**Other**	**Main Concerns:**	
Referral to be seen immediately Yes ☐ **No** ☐ ☐ **(will be on Waiting List)**			
Occupational Therapist Signature:			

E. Release of Information and Consent to Assessment:

I _____ (name of parent/guardian), who is the Custodial Parent/Guardian of _____ (child's name), provide consent to release/share information relevant to the care and status of this child to the KidsAbility P4C Occupational Therapist as deemed necessary in the provision of School Based Rehabilitation Services, on _____ (date DD/MM/YYYY).

The Custodial Parent/Guardian consents to:

- KidsAbility entering the referral information into its database.
- KidsAbility exchanging and share information with School and School Board/School and School Board will exchange and share information with KidsAbility.
- KidsAbility P4C Occupational Therapist accessing information contained in the Ontario School Record if required.

I understand that I have the right to refuse or withdraw this consent at any time by providing written notice, but the withdrawal of consent shall not have retroactive effect. I understand that refusal to provide consent may impact KidsAbility's ability to provide services. I understand no information is released for any other purposes, without my consent, unless required by law and that my consent is valid for as long as the above named is receiving School Based Rehabilitation Services. I understand that it is my responsibility to inform any other guardian of this referral, that documentation may be requested in situations of joint/shared or sole custody and that information will be shared with both guardians upon request, unless documentation indicates otherwise.

_____ _____
Signature of Parent/Legal Guardian or Client (if 18 years or older) Date

_____ _____
Signature of Principal/Designate Date

Please email to the secure KidsAbility Portal: https://sbrs.kidsability.org, KidsAbility recipient: Rebecca Tucker at sbrs@kidsability.ca or FAX: 519-886-7292 Attention: SBRS - CSA

Form Date: March 2022