KidsAbility™

Shared Referral Form for School Health Support Services and School Based Rehabilitation Services
Waterloo Region and Guelph-Wellington

KidsAbility Centre for Child Development Fax to: 519-886-7292 Questions? Call: 519-886-8886 or 1-888-372-2259 x 1214	**Home and Community Care Support Services Waterloo Wellington** Fax to: 519-571-3961 Questions? Call: 519-883-5500 or 1-888-883-3313
Services Requested: KidsAbility *Occupational Therapy ☐ *Physiotherapy ☐ *Speech Therapy ☐ ☐ Urgent equipment needs required for school entry (i.e. ramp, grab bars, mobility device)	**Services Requested: HCCSSWW** Nursing ☐ Personal Support ☐ **For Private School or Home-Schooled ONLY: HCCSSWW** *Occupational Therapy ☐ *Physiotherapy ☐ *Speech Therapy ☐ **Health Card Number (required):**
☐ Request for service in French-if attending French school	☐ Request for service in French-if attending French school

*Supporting documentation must accompany referral

A. Child/Youth Demographics

Surname:				**First Name:**	
Date of Birth (dd/mm/yy):				**Gender:**	
Address:				**City:**	**Postal Code:**
Parent/Guardian Name:					
	Legal Guardian:	**Y** ☐	**N** ☐	**Relationship:**	
	Living With Child:	**Y** ☐	**N** ☐		
	Address:	**Same** ☐	**Other** ☐ **(please include below)**		
				City:	**Postal Code:**
	Home Phone #:		**Cell Phone #:**		**Work #:**
	Email:			**Email Consent^: Y** ☐ **N** ☐	
Parent/Guardian Name:					
	Legal Guardian:	**Y** ☐	**N** ☐	**Relationship:**	
	Living With Child:	**Y** ☐	**N** ☐		
	Address:	**Same** ☐	**Other** ☐ **(please include below)**		
				City:	**Postal Code:**
	Home Phone #:		**Cell Phone #:**		**Work #:**
	Email:			**Email Consent^: Y** ☐ **N** ☐	
Custody Arrangements:					
Joint ☐		**Sole** ☐		**No Agreement** ☐	**Formal Agreement** ☐
Comments/Details:					

^Consent for use of email to receive handouts, letters, information about programs and events, and/or to schedule appointments. Consent can be withdrawn at any time. To opt out of specific types of communication, please indicate in the space provided.

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Ontario Local Health Integration Network

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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:**	**Fax:**

D. Release of Information and Consent to Assessment:

I authorize KidsAbility and HCCSSWW to collect, use and disclose relevant information regarding

_____ (client's name) to health professionals/agencies, institutions, or individuals involved for the purpose of prioritization, assessment for eligibility, service planning, treatment/care, and program evaluation of the School Health Support Services Program and/or School Based Rehabilitation Services. I authorize KidsAbility and HCCSSWW to access information contained in the Ontario School Record if required. I understand 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 and HCCSSWW'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 Health Support Services and/or School Based Rehabilitation Services. I understand 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