



SCHOOL COMMUNITY INTERVENTION PARTNERSHIP (SCIP) REFERRAL FORM

Email completed referral to information@scipinlondon.com or FAX to (519) 432-0056

Please Complete All Sections:

Date Referral Completed (Y/M/D) :

LDCSB

TVDSB

* Parent/Guardian Consent Obtained: Yes

STUDENT INFORMATION

Name:	DOB: Y/M/D
Address with Postal Code:	EMAIL:
Phone #: Has parent given consent for SCIP to leave a message at this number? <input type="checkbox"/> Yes <input type="checkbox"/> No	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female

SCHOOL INFORMATION

Referring School:	Grade:	Class Size:
Address:	Principal:	
Phone #:	Teacher:	Teacher Email:

SCHOOL -BASED RESOURCES – NOW OR IN THE PAST

<p>Psychology Services: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when: Name: Phone #: Ext. Email:</p>	<p>Social Worker/School Support Counsellor: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when: Is the social worker aware of the referral? <input type="checkbox"/> Yes <input type="checkbox"/> No Name: Phone #: Ext. Email:</p>
<p>Behavioural Services: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when: Are they aware of the referral? <input type="checkbox"/> Yes <input type="checkbox"/> No Name: Phone #: Ext. Email:</p>	<p>LST/SPST: <input type="checkbox"/> Yes <input type="checkbox"/> No Is primary contact person? <input type="checkbox"/> Yes <input type="checkbox"/> No Name: Phone #: Ext. Email:</p>
<p>Contact Person (if other than LST/SPST): Phone #: Ext. Email:</p>	

PARENT INFORMATION

<p>Parent/Guardian Name: j</p>	<p>Relationship:</p>	<p>Custodial Parent: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Home Address (if different from above):</p>	<p>Home Phone #: Has parent given consent for SCIP to leave a message at this number? <input type="checkbox"/> Yes <input type="checkbox"/> No Cell Phone #: Has parent given consent for SCIP to leave a message at this number? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Place of Employment:</p>	<p>Work Phone #: Has parent given consent for SCIP to leave a message at this number? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Parent/Guardian Name:</p>	<p>Relationship:</p>	<p>Custodial Parent: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>

Classroom Support Now or in the Past: (check all that apply)

Educational Assistant Steps for Success Classroom Volunteer Peer Support

Behaviour Team/TOSA Please Describe:

Technological Support Please Describe:

Modified Day/Schedule Please Describe:

Sensory/Environmental Adaptations: Please Describe:

IPRC: Yes No If yes, type of exceptionality:

IEP: Yes No If yes, copy attached? Yes No

Behavioural Plan in place? Yes No If yes, copy attached? Yes No

Safety Plan in place? Yes No If yes, copy attached? Yes No

School Based Assessment/Observation

Psychological	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Academic	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Speech and Language	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Behaviour Resource Teacher	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Occupational Therapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Other Interventions/Services

Knowledge of access to Community-Based Programs/Agency Involvement/Assessment/Diagnosis

Date (Y/M/D)	Name and position or signature of school contact person (Required) who obtained consents.
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Date (Y/M/D)	Verbal Consent (name and position) or signature of Principal (Required)
Date (Y/M/D)	<p>VERBAL CONSENT – (NAME OF PARENT/GUARDIAN) OR SIGNATURE</p> <p>I agree to have the above referral information released and exchanged between the School Board and SCIP/Vanier for the purpose of accessing services.</p> <p>Parent/Guardian Name of Signature (Required)</p>