Fraser Valley
Child Development Centre

# REFERRAL FOR SCHOOL AGED SERVICES
## School Referral Form for Occupational & Physical Therapy Services

**Date Received:** _____

**Student Information:**

Student's Name: _____
(Surname) (Given Names)

Home Phone Number: _____ Alternate Phone Number: _____

Birth Date: _____ Age: _____ PHN Number: _____
Day/ Month/ Year

Home Address: _____

Parent/Guardian's Names: _____

Social Worker's Name: _____ Phone Number: _____

Diagnosis: _____ Designation Category: Yes ❒ No ❒

_____ Specify: _____

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**School Information:**

School: _____ Principal: _____

Teacher(s): _____ Education Assistant: _____

Primary Contact at School: _____ Grade: _____

Student's Case Manager at School: _____

Hours of EA time that the student currently receives: _____

Person(s) responsible for following up on Therapist's recommendations: _____

Other District Support Staff (SLP, Psychology, etc.): _____

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**Date of Request:** _____ **OT Consult:** _____ **PT Consult** _____

**Reason for Referral:**

1. What are the main concerns for this student?
   a. _____
   _____
   b. _____
   _____
   c. _____
   _____
   d. _____

2. Goals for OT/PT Services (please be specific): _____
_____
_____

Referring Staff Signature: _____ Parent Signature: _____

Student Services Signature: _____ Comments: _____