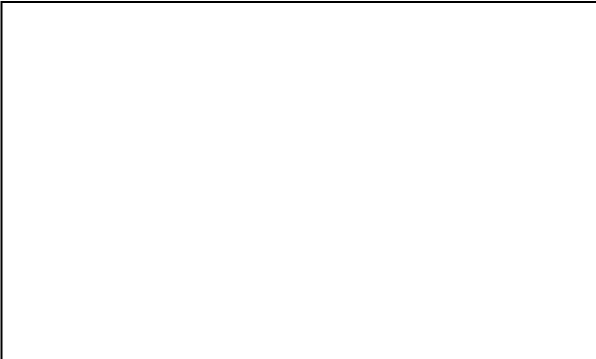
Digby - Shelburne – Yarmouth



SCHOOL THERAPY REFERRAL FORM

☐ **Digby General Hospital**	☐ **Yarmouth Regional Hospital**	☐ **Roseway Hospital**
Phone: (902) 845-2502 Ext 3257	Phone: (902) 742-3542 Ext 1137	Phone: (902) 875-4144 Ext 2204
Fax: (902) 245-3000	Fax: (902) 749-0759	Fax: (902) 875-2911

Date ______________________________

Student Name______________________________

Diagnosis ______________________________

DOB ______________________ School ______________________

Health Card # ______________________ Grade (for referral year)______________________

Parent/Guardian ______________________ School Year: 20_________ - 20_________

______________________ School Contact ______________________

Address ______________________ Title ______________________

______________________ School Phone #______________________

Home Phone # ______________________ Email: ______________________

☐ Please confirm receipt of referral to above email contact

Please describe reason for referral:

School's Concerns: ______________________________

____

Parents' Concerns: ______________________________

____

Please identify any specific safety concerns: ______________________________

____

Has this student been previously seen by OT, PT or Recreation Therapy? ☐ Yes ☐ No

When? ______________________________

If 'Yes', has the most recent report been reviewed? ☐ Yes ☐ No

If 'Yes', please indicate the reason for re-referral: ☐ New goals identified

☐ Change in functional status ☐ Need for staff education/training

☐ Complex physical/equipment needs ☐ Other ______________________________

Is the student transitioning into: ☐ New School ☐ Primary ☐ Junior High ☐ High School
☐ New location ☐ Community/Post-High School For school year 20_____ - 20_____

Program Support:

This student has: Individual Program Plan: ☐ Yes ☐ No
Documented Adaptations: ☐ Yes ☐ No

Teacher Assistant Support: ☐ Yes ☐ No
How often? _______________ For what? ____
____

Resource Support: ☐ Yes ☐ No
How often? _______________ For what? ____
____

Learning Centre Support: ☐ Yes ☐ No
How often? _______________ For what? ____
____

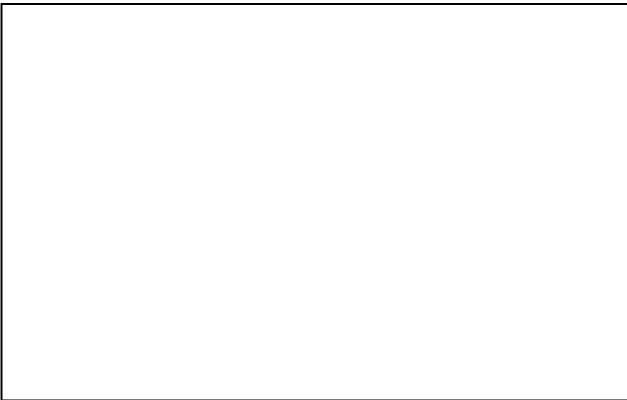
Comments: ____
____

Other Information:

Please describe any behavioral/social concerns (e.g. attention, peer interaction): _______________
____
____

Please identify student's interests and extracurricular activities: ____________________________
____
____

Please list any other services, professionals, or clinics involved with the student: ______________
____
____



Student Profile:

Please Score Each of the Following 4 Items According to Scale Below

Item 1: Personal Care **Score:** ____________

Retrieves food items, sets up snack/meal, and feeds self

Describe: ____

Dresses self

Describe: ____

Completes bathroom routine

Describe: ____

Equipment: ____

Item 2: Mobility/Functional Gross Motor Skills **Score:** ____________

Able to stand and walk without difficulty (does not trip, lose balance, fall)

Describe: ____

Able to move between chair and floor, transfer on/off toilet, from sitting to standing, etc.

Describe: ____

Participates in physical education class, playground activities, recreational school activities

Describe: ____

Equipment: ____

Item 3: Classroom Productivity **Score: ___________**

Able to complete handwritten work legibly, and in an appropriate amount of time

Describe: ____

Able to participate in classroom routines (e.g. organizes/cares for school supplies, hangs up coat, transitions between activities)

Describe: ____

Able to manipulate objects (scissors, glue, protractors, toys, crayons)

Describe: ____

Equipment: ____

Item 4 Environment **Score: ___________**

Able to move freely about the school environment with no physical barriers (inside, outside, stairs, bathroom)

Describe: ____

Accesses school supplies and materials

Describe: ____

Sits comfortably at desk (e.g. able to access, feet supported on floor & back against back of chair)

Describe: ____

Equipment: ____

Based on the above information, please prioritize your goals for School Therapy Services:

1. ____
   ____
2. ____
   ____
3. ____
   ____

If this referral is regarding sensory or behavioral issues please complete and include a Self Regulation Questionnaire

Referral Source: ____________________________ **Signature:** ___________________________

Parent/Guardian: ___________________________ **Signature:** ___________________________