 

**SCHOOL COMMUNITY INTERVENTION PARTNERSHIP (SCIP) REFERRAL FORM**

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

# Please Complete All Sections:

Date Referral Completed (Y/M/D):

# \* Parent/Guardian Consent Obtained: Yes

STUDENT INFORMATION LDCSB

TVDSB

|  |  |  |
| --- | --- | --- |
| Name: | DOB (Y/M/D): | |
| Address with Postal Code: | **EMAIL**: | |
| Phone #: | Gender:  Male | Female |
| Has **parent** given consent for SCIP to leave a |
| message at this number? |
| Yes  No |

SCHOOL INFORMATION

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

SCHOOL -BASED RESOURCES – NOW OR IN THE PAST

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

PARENT INFORMATION

|  |  |  |
| --- | --- | --- |
| Parent/Guardian Name: | Relationship: | Custodial Parent:  Yes  No |
| Home Address (if different from above): | Home Phone #:  Has parent given consent for SCIP to leave a message at this number?  Yes  No  Cell Phone #:  Has parent given consent for SCIP to leave a message at this number?  Yes  No | |
| Place of Employment: | Work Phone #:  Has parent given consent for SCIP to leave a message at this  number?  Yes  No | |

|  |  |  |
| --- | --- | --- |
| Parent/Guardian Name: | Relationship: | Custodial Parent:  Yes  No |
| Home Address (if different from above): | Home Phone #:  Has parent given consent for SCIP to leave a message at this number?  Yes  No  Cell Phone #:  Has parent given consent for SCIP to leave a message at this number?  Yes  No | |
| Place of Employment: | Work Phone #:  Has parent given consent for SCIP to leave a message at this  Number?  Yes  No | |

REASON FOR REFERRAL (TO BE COMPLETED BY SCHOOL):

|  |
| --- |
| *Please list dysregulated behaviours leading to this referral. Please indicate/comment on academics, attendance, social/peer relations. Also indicate any strategies already implemented in an effort to support the youth.* |

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| --- |
| **School’s View of Child Strengths**:    **School’s View of Child and Family Needs**:    **School’s Expected Outcomes/Goals for the Child**: |

***Please list dysregulated behaviours leading to this referral. Please indicate/comment on academics, attendance, social/peer relations. Also include any strategies already implemented in an effort to support the youth.***

School’s View of Child’s Strengths:

|  |
| --- |
| **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 | Yes  No |
| Academic | Yes  No |
| Speech and Language | Yes  No |
| Behaviour Resource Teacher | Yes  No |
| Occupational Therapy | Yes  No |
| Other Interventions/Services | |

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

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

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

September 2025 MVCS.SCIP.06