 

**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):

# \* 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

|  |  |
| --- | --- |
| 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 [ ]  NoIf 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 [ ]  NoName:      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 [ ]  NoCell 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 [ ]  NoCell 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):

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| *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:

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| --- |
| **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:       |

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| IEP: [ ]  Yes [ ]  No If Yes, copy attached? [ ]  Yes [ ]  NoBehavioural Plan in Place? [ ]  Yes [ ]  No If Yes, copy attached? [ ]  Yes [ ]  NoSafety 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