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? ☐ Yes ☐ No	Gender: ☐ Male ☐ Female

SCHOOL INFORMATION

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

SCHOOL -BASED RESOURCES – NOW OR IN THE PAST

Psychology Services: ☐ Yes ☐ No If yes, when: Name: Phone #: Ext. Email:	**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 ☐ No If yes, when: Are they aware of the referral? ☐ Yes ☐ No Name: Phone #: Ext. Email:	**LST/SPST**: ☐ Yes ☐ No Is primary contact person? ☐ Yes ☐ No Name: Phone #: Ext. Email:
Contact Person (if other than LST/SPST): 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 include any strategies already implemented in an effort to support the youth.

School's View of Child's Strengths:

School's View of Child and Family Needs:

School's Expected Outcomes/Goals for this Child:

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	

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.
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 of Signature **(Required)**