Updated Jan. 2023

niagara children's centre school
Weaving education and therapy together for student success.

Niagara Children's Centre School Authority
Referral Checklist

Child's Last Name		**Child's First Name**			
Gender	☐ M ☐ F	**Date of Birth (yyyy/mm/dd)**			
Medical Diagnosis (If applicable)					
Mother/Guardian Name		**Father/Guardian Name**			
Home Address		**City**		**Postal Code**	
Home Phone Number		**Cell/Work Phone Number**		**E-mail**	
Niagara Children's Centre Contact/Team		**Phone Number**		**E-mail**	
Home (Community) School		**Phone Number**			
Teacher/ Resource Teacher		**School Board Affiliation**	**DSBN** ☐	**NCDSB** ☐	**Other** _____
Daycare/ Preschool		**Phone Number**		**Days Attending**	☐M ☐T ☐W ☐Th ☐F ☐AM ☐PM ☐Full
Family Physician Name		**Phone Number**			
Specialist Name		**Phone Number**			
Specialist Name		**Phone Number**			

Office Use Only

Referral Received _____ Video Received _____ Referral Complete ☐Y ☐N

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Child's Name: _____ Date of Birth: _____

PLACEMENT GOALS (PLEASE INDICATE A GOAL IN <u>EACH</u> AREA):

Goal Area 1 (Check One)

☑ Child has **<u>not previously attended school</u>** and **<u>requires comprehensive interdisciplinary assessment</u>** to develop learning strategies for classroom participation and school based therapy intervention plan.

☐ Child is **currently in school** but has had a **<u>change in their condition or circumstances</u> that requires comprehensive reassessment to revise current IEP or school based therapy intervention plan and/or substantial revision of strategies or complex equipment prescription.**

☐ Child has a **newly acquired or acute post-operative condition** that requires a period of intensive therapy

Goal Area 2 (Check all that apply)

Child requires development/revision and trialing of strategies for classroom participation in the areas of (check all that apply):

☐ Communication

☐ Mobility

☐ Self Care / Activities of Daily Living

☐ Learning

Goal Area 3 (Check all that apply)

Child requires trialing and prescription of equipment in the areas of:

☐ Face to Face Communication (must meet eligibility criteria)

☐ Written Communication (technology driven)

☐ Mobility

Please identify any additional goals to enhance participation in the school setting:

_____
_____
_____
_____

Is there any additional Information that you wish for us to consider:

_____
_____
_____
_____
_____

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Child's Name: _____ Date of Birth: _____

PARENT INPUT (Must be completed by the parent/legal guardian for all referrals):	**YES**	**NO**
A. I have seen the entire referral package being submitted on behalf of my child.	☐	☐
B. Are the concerns identified by the school staff also observed at home?	☐	☐
C. Please indicate any additional concerns and/or comments.		
D. I am willing to attend assessment and/or follow-up visits at school.	☐	☐
E. I am willing to attend school therapy sessions, parent education and engagement sessions, or group sessions, if recommended as part of my child's services.	☐	☐
F. I am willing to follow through with home programming recommendations.	☐	☐
Name of Parent/Legal Guardian: _____ Signature: _____		

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CURRENT CHILD STATUS

The following information is based on observation, previous assessment, and parent report.

Date Completed: _____ Completed by:_____

Please Note: If a Preschool Services Functional Checklist has been completed on the child for this academic year, please attach and skip section A, otherwise please complete all sections. If the sub-category does not apply to the student being referred please write not applicable in the comment section of the section.

SECTION A: FUNCTIONAL SKILLS

	Skill not developed	With assistance	Independent	
Gross Motor Function:				**Comments**
Sitting				
Standing				
Walking (without assistive device)				
Mobility (with assistive device)				
Exhibits protective reactions				
Balance on Indoor surfaces				
Balance on Outdoor surfaces				
Fine Motor and Self-Help Skills:				**Comments**
Bilateral Manipulation of objects				
Dressing				
Eating				
Academic				**Comments**
Sits at Circle Time or for an activity				
Transitions well between activities				
Attends to task				
Demonstrates table/desk top readiness				
Behaviour	**Always**	**Sometimes**	**Never**	
Separates easily from caregiver				**Comments**
Follows routines/teacher requests				
Aggressive towards adults				
Aggressive towards peers				
Aggressive towards self				
Throws objects				
Interacts socially with peers				
Exhibits age appropriate play skills				
Easily over stimulated				
Play Skills:	**Always**	**Sometimes**	**Never**	
Plays spontaneously with objects demonstrating their function				
Demonstrates symbolic play				
Plays comfortably in a small group of children				
Safety Concerns:	**Always**	**Sometimes**	**Never**	
Mouths inedible objects				**Comments**
Leaves classroom without warning				
Puts self in danger				
Climbs stairs independently				
Plays safely on playground equipment				

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Communication: (check any that apply)	Comments:
Articulation (production of speech sounds)	
☐ Hoarseness ☐ Nasality ☐ Dysfluency (Stuttering)	
Receptive Language (Oral Comprehension)	
▬ Understands Oral vocabulary & directions ▬ Understands verbal messages/stories ▬ Understands Basic Concepts (spatial, quantity) ▬ Responds Appropriately to Oral Questions/Follows Directions ☐ Responds to name	
Expressive Language (Spoken Language)	
☐ Demonstrates oral grammar/sentence structure ☐ Uses appropriate vocabulary to label objects ☐ Organizes/sequences messages ☐ Is able to tell stories orally	
Conversation Skills	
☐ Initiates conversation ☐ makes/maintains Eye Contact ☐ maintains Topic ☐ takes turns	
Other	
☐ Uses a visual schedule or graphics ☐ Uses a speech generating device (please specify) _____	

SECTION B: ADDITIONAL SCHOOL READINESS SKILLS

	Almost Always	Sometimes	Seldom	Examples
Invites others to join in play				
Is able to share emotions, express feelings with adults and peers				
Uses effective strategies for self-calming				
Uses all senses to gather information while observing				
Is able to identify sounds in their environment (traffic noise)				
Is able to Identify specific letter sounds and syllables				
Is able to isolate sound combinations				
Identifies the letter that begins their name and its sound				
Uses complex sentences (5 to 7 words in length)				
Uses age appropriate vocabulary and is able to use new words in play				
Able to identify problems				
Pretends to be someone during dramatic play activities				
Spends time with books				
Pretends to read				
Makes connections between books and stories during play				
Expresses self in print				

Uses paper and pencil to scribble				
Pretends to write or can write words or letters				
Uses concept of print (left to right page progress etc…)				
Uses objects to construct graphs				
Creates pictorial graphs				
Is able to sort objects, pictures and things into groups				
Is able to compare one object to another				
Is able to count to determine quantity				
Is able to count in a meaningful way in play and daily living				
Uses counters to represent objects				
Recognizes and names shapes				
Recognizes patterns in their environment				
Creates patterns with blocks and other materials				
Is able to identify more, less, than or same as				
Can make more or less comparisons				
Recognizes relationships between attributes (weight and size; size and capacity				
Points to and describes relative position (before, after, between, front, back etc…)				
Uses spatial terms (forward, backward, inside, next, behind, in front etc…)				

SECTION C: OTHER INFORMATION

Current Equipment

- ☐ Stander _____
- ☐ Walker _____
- ☐ Orthotics _____
- ☐ Wheelchair _____
- ☐ Communication/Writing Aids _____
- ☐ Specialized Feeding: □bowl □spoon □other: _____
- ☐ Specialized Seating: □table □floor □other: _____
- ☐ Transfer Equipment: □lift □sling □other: _____
- ☐ Sensory (specify):_____
- ☐ Other (specify):_____

Current Therapies

(please include name & agency of therapist and if not a Niagara Children's Centre clinician attach any recent reports)

- ☐ OT Therapist's Name:_____
- ☐ PT Therapist's Name:_____
- ☐ Speech Therapist's Name:_____
- ☐ Behaviour: ABA/IBI Therapist's Name/Provider: _____
- ☐ Other: _____

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Agency Supports

(please specify agency contact names & phone number)

- ☐ Niagara Children's Centre Social Worker: _____
- ☐ Bethesda: _____
- ☐ Pathstone: _____
- ☐ FACS: _____
- ☐ BLV or VLRO: _____
- ☐ LHIN: _____
- ☐ Other: _____

Toileting

- ☐ Toilet trained
- ☐ Not toilet trained

____Pull ups / Diapers _____Toilet seat/commode ____Stands up to change
____Change table required

- ☐ Requires catheterization

Other Special Considerations

- ☐ Seizures
- ☐ Diabetic
- ☐ Allergies_____
- ☐ Asthmatic
- ☐ Medication required at school _____
- ☐ Nursing _tube feed _oxygen _suctioning / other: _____
- ☐ Transportation concerns _____
- ☐ Hearing concerns – Most recent hearing test _____

Hearing Aids □Yes □No
Cochlear Implant □Yes □No

- ☐ Vision concerns – Most recent vision test _____

Wears Glasses □Yes □No
Followed regularly □Yes □No
If yes, by whom:. _____
(Name of Optometrist/Ophthalmologist)

SECTION D: ASSESSMENT INFORMATION

	Yes	No	Date of Assessment/Comment
Educational Assessment			
School Board/SBRS Speech or Language			
SBRS Occupational Therapy			
SBRS Physiotherapy			
Psychological Assessment			
Other:			

Note: If assessments have been completed, please attach.

SECTION E: CURRENT EDUCATIONAL INFORMATION (To be completed for current school-age applicants)

1. Does child have an Individual Education Plan? Yes___ No___ N/A___ If yes please attach
2. Has child had an IPRC? Yes____No___N/A___
3. Does child receive educational assistant support? Yes____No___N/A___
   If yes, provide details (number of hours/shared or individual support, etc.) _____
4. Does child have a behaviour plan? Yes___ No___ N/A___ If yes please attach
   Does child have a safety plan? Yes___ No___ N/A___ If yes please attach
   Is the student on a modified day? Yes ____ No _____ If yes, please provide details

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If you have questions please contact:

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OR

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