Connecting you with care
Votre lien aux soins

South West CCAC / CASC
Community Care Access Centre
Centre d'accès aux soins communautaires du Sud-Ouest

REQUEST FOR SCHOOL HEALTH SUPPORT SERVICES

Student Surname: _____

Given Name: _____

Sex: (M) (F) Date of Birth: _____ (DD/MM/YY)

Health Card: _____ VC: _____

FAMILY INFORMATION

Parent/Guardian Name(s): _____

Cell/Business Tel.: Mother: _____ Father: _____

Permission to contact Mother at work: (Y) (N) Permission to contact Father at work: (Y) (N)

Parents informed consent received: (Y) (N) Date: _____ (DD/MM/YY)

Mailing Address (911/Box#): _____

City: _____ Code: _____ Tel.: _____

CAS/Homeshare/Other Contact: _____

Referral Initiated by: _____ Relationship: _____

Tel.: _____ Date: _____ (DD/MM/YY)

Family Physician: _____ Specialist: _____

Known Diagnosis: _____

SCHOOL INFORMATION

School: _____ Tel.: _____

Attendance: AM ☐ PM ☐ Full Day ☐ Alternate Days ☐ Grade: _____

Principal: _____ Teacher: _____

Resource Person: _____

Which school personnel will be responsible for follow-up of recommendations provided by the therapist?:

Name: _____ Telephone: _____ Best time to call: _____

REFERRAL INFORMATION

Assessment requested: ☐ OT* ☐ PT* ☐ Speech* ☐ Nursing ☐ Nutrition

**all referrals must be accompanied by an appropriate screening tool*

List or attach any specialized testing (e.g. Psychology, Psychometry, Speech, Agency/Treatment Centre, etc.):

What interventions have been implemented to accommodate this student's strengths and needs?

Preschool Speech Agency: _____ Date Preschool SLP Spoke with Board SLP: _____

Authorized by: _____ Title: _____ Date: _____

PRESCHOOL SLP/BOARD SLP OR SCHOOL PRINCIPAL/DESIGNATE

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