

PROVINCIAL INTEGRATION SUPPORT PROGRAM	1525 Rowan Street Victoria BC, V8P 1X4 TEL: (250) 595-2088 FAX: (250) 592-5976	REFERRAL FORM	
	Coordinator: Terry Wendorf Email twendorf@sd61.bc.ca Website: www.pisp.ca		
• Please attach IEP including date and people involved.	I. STUDENT INFORMATION		PEN #
• Have you done a MAPS for the student or any other long-term goal setting? Yes _____ No _____	Surname:	Given Name(s):	
	Birthdate:	Gender:	Referral Date:
<i>Please return completed referral package to:</i> Terry Wendorf, Coordinator – Provincial Integration Support Program 1525 Rowan Street, Victoria, BC, V8P 1X4	Home Address:		
	Diagnosis:	Ministry Funding Category:	
II. SCHOOL INFORMATION	Please include your Email address (if applicable)		
Key Contact Person & Position:		Phone + Area Code:	
Address:		Postal Code:	Fax:
Name of School:		Classroom Placement	Phone + Area Code:
School Address:	City:	Postal Code	Fax:
Teacher:		Teaching Assistant	
Principal		School Hours (e.g., 8:40 – 12:00; 1:00 – 3:00)	
School District Name:		District No.:	Phone + Area Code:
District Address:	City:	Postal Code:	
Director of Special Education		District Partner	
III. PARENT/GUARDIAN INFORMATION			
Parent/Guardian Name & Address, Postal Code:		Phone (Home) + Area Code:	
Foster Parent/Associate Family Name & Address, Postal Code:		Phone (Home) + Area Code:	
MCF Social Worker Name & Address:		Phone + Area Code:	
		Fax:	
Has this student been referred to and/or received services from other Provincial Outreach Programs?			
<input type="checkbox"/> SET-BC <input type="checkbox"/> Provincial Outreach Program for Students with Deaf/Blindness <input type="checkbox"/> Provincial Outreach Program for Autism & Related Disorders		<input type="checkbox"/> Vision Outreach Program <input type="checkbox"/> Other	
Please specify:			
SIGNATURES: Parent:		District Partner:	
Principal:		District Admin	
Please note: Cost for release time for team meetings for teacher(s), teaching assistant(s) and district support staff is covered by the student's district			
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STUDENT STATUS

1. Positioning/Mobility

How does the student move around in school and at home?

Manual Wheelchair Power Wheelchair Walker Ambulatory

What are the different positions the student uses in the classroom and at school?

Standing Frame Sidelyer

Other (please elaborate)

2. Fine Motor / Gross Motor Coordination– is the student CURRENTLY using fine/gross motor skills in one or more of the following?

Switch Activities (specify) (e.g. Powerlink) _____

School Activities (specify) _____

Rec/Leisure Activities (specify) _____

Self Care Activities (specify) _____

3. Sensory Impairment – Has the student been identified as having a sensory impairment?

Visual Hearing Other

Please elaborate on extent of sensory impairment: _____

4. Communication Skills

(a) What is the student's CURRENT level of communication?

Speaking Non-speaking Speech Difficulty (please comment) _____

(b) If the student uses augmentative/alternative communication systems, please indicate the student's primary mode of communication.

Sign Language _____

Non-Formalized Communication System _____

(e.g. gestures, facial expression)

Non-Technical Aids (specify type e.g. communication board, object choices, pictures choices)

Technical aids (specify type e.g. BIGmack) _____

(c) Receptive understanding of language – Does the student demonstrate by his/her actions:

Simple routine commands Simple routine questions

Please elaborate: _____

5. Activities of daily living – Student needs assistance with

Eating Dressing Toileting Safety

6. Please provide us with any information on the student's current health requirements which could be of assistance to us in providing services (e.g. seizure activity, timed medication, special rest periods, gastrostomy tube, level of care for the student).

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AUDIO/VISUAL SAMPLE OF STUDENT
(Send DVD or VHS tape format)

In order to assist in this referral, please provide a DVD/videotape of the student.
The entire segment should run no longer than 10 minutes and include the areas listed below.

1. The student moving down the hallway and entering his/her classroom (Independent mobility if possible).
2. The student sitting in his/her usual classroom chair.
3. Close-up of the student's face during an activity (e.g., looking at a storybook).
4. A close-up of the student using any equipment (e.g. communication, positioning and adaptive).
5. The student demonstrating an activity which requires hand use (e.g. switch use, reaching and grasping, etc.).
6. A structured classroom activity involving the student (e.g. choice making).
7. The student involved in one-to-one conversation.
8. The student involved in his/her favorite activity.
9. The student involved in an eating activity.
10. The student engaged in communication (e.g. pointing, sign language, choice making).

NOTE: ♦ Note that it is the school's responsibility to obtain parental permission before making the DVD/videotape
♦ Remember to review the tape to ensure proper recording

PARENTAL CONSENT FOR AUDIO/VISUAL SAMPLE OF STUDENT

I request that this DVD/videotape of my child be released to Provincial Integration Support Program in order to assist them in evaluating this referral.

I understand that this DVD/videotape will be kept by Provincial Integration Support Program and will not be released without my permission.

Student's Name: _____ Birthdate: _____

Date(s) of taping: _____

Teacher (please print): _____ Signature: _____

Parent/Guardian (please print): _____ Signature: _____

Witness (please print): _____ Signature: _____

Signed at (location): _____

This _____ day of _____ 20____

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AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby request that the Provincial Integration Support Program to obtain information from and give information to necessary contacts regarding my child. I also waive any and all claims against program staff for all purposes whatsoever arising from the disclosure of information contained in the records.

Name of Student: _____ Parent/Guardian (please print): _____ Witness (please print): _____ Signed at (location): _____	Birthdate: _____ Signature: _____ Signature: _____ This _____ day of _____ 20_____ (valid for a period of three years from this date)
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SUPPORT SERVICES RECEIVED FROM SCHOOL DISTRICT

NAME	PHONE	FAX	EMAIL (if applicable)	COMPLETE MAILING ADDRESS
District Occupational Therapist				
District Physiotherapist				
District Speech/Language Pathologist				
District Teacher of the Deaf & Hard of Hearing				
District Teacher of the Visually Impaired				
Other				

NOTE: Applicable Release of Authorization forms for Hospitals will be forwarded by mail. (e.g., Queen Alexandra Centre for Children's Health, Children's & Women's Health Centre of British Columbia (SunnyHill), B.C. Children's Hospital, Alberta Children's Hospital).

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Please outline with as much detail as possible what you would like to receive from the Provincial Integration Support Program team, which questions you would like answered, as well as specific problems or areas of concern your team members may have.