

# PROVINCIAL INTEGRATION SUPPORT PROGRAM

1525 Rowan St.  
Victoria BC, V8P 1X4

TEL: (250) 595-2088  
FAX: (250) 592-5976

# REFERRAL UPDATE

email: twendorf@sd61.bc.ca

Website: www.pisp.ca

•Please attach IEP including date and people involved

•Have you done a MAPS for the student  
or any other long term goal setting?  
\_\_\_ Yes \_\_\_ No

**Please return completed referral package to:**  
Terry Wendorf,  
Provincial Integration Support Program  
1525 Rowan Street, Victoria, B.C. V8P 1X4

## I. STUDENT INFORMATION

PEN #

Surname		Given Name(s)	
Birthdate	Gender	Referral Date	
Home Address			
Diagnosis		Ministry Funding Category	

## II. SCHOOL INFORMATION

Please include your email (if applicable)

Key Contact Person & Position		Phone + Area Code
Address		Postal Code
		Fax
Name of School	Classroom Placement	Phone + Area Code
School Address		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		Postal Code
		Fax
Director of Special Education	District Partner	

## III. PARENT/GUARDIAN INFORMATION

Parent/Guardian Name, Address, Postal Code	Phone (Home) + Area Code
	Phone (Work) + Area Code
Foster Parent/Associate Family Name & Address	Phone (Home) + Area Code
	Phone (Work) + 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?

\_\_\_ SET-BC  
\_\_\_ Provincial Outreach Program for Students with Deaf/Blindness  
\_\_\_ Provincial Outreach Program for Autism & Related Disorders

\_\_\_ Jericho Outreach Program  
\_\_\_ Vision Outreach Program  
\_\_\_ Other

Please specify:

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## 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

**PROVINCIAL INTEGRATION SUPPORT PROGRAM REFERRAL UPDATE FORM**

*Please return completed referral update package to:*

Terry Wendorf • Coordinator • Provincial Integration Support Program•

1525 Rowan Street • Victoria, BC • V8P 1X4• Tel: (250) 595-2088 Fax: (250) 592-5976

**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: _____	Birthdate: _____
Parent/Guardian (please print): _____	Signature: _____
Witness (please print): _____	Signature: _____
Signed at (location): _____	This _____ day of _____ 20____ (valid for a period of three years from this date)

**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).