North Shore Pediatric Resource Team
241-2121 Marine Drive
West Vancouver, B.C. V7V 4Y2
Phone: 778-886-7619
Fax: 604-913-0066

# REFERRAL FOR SCHOOL AGED PHYSIOTHERAPY SERVICES

CLEAR FORM

| **Section 1 – Student Information (PLEASE PRINT)** | | | |
|---|---|---|---|
| STUDENT'S FIRST NAME | STUDENT'S LAST NAME | MSP Personal Health Number | DATE OF BIRTH (DD/MM/YYYY) |
| ADDRESS | CITY | POSTAL CODE | STUDENT'S GENDER |

| **Section 2 – Parent(s)/Guardian Information (PLEASE PRINT)** | | |
|---|---|---|
| NAME OF PARENT OR GUARDIAN (FIRST AND LAST)<br>□Mother □Father □ MCFD SW | HOME TELEPHONE<br>WORK TELEPHONE | EMAIL |
| NAME OF PARENT OR GUARDIAN (FIRST AND LAST)<br>□Mother □Father □ MCFD SW | HOME TELEPHONE<br>WORK TELEPHONE | EMAIL |
| LANGUAGES SPOKEN AT HOME | IS ENGLISH UNDERSTOOD?<br>□ Yes □ No | STUDENT RESIDES WITH<br>□ Parent(s)<br>□ Other caregiver (Name) |

| **Section 3 – School Information (PLEASE PRINT)** | | |
|---|---|---|
| SCHOOL NAME | GRADE | ☐ LEARNING SUPPORT TEACHER or<br>☐ CASE MANAGER |
| TEACHER/CASE MANAGER'S NAME | SPECIAL EDUCATION ASSISTANT | OCCUPATIONAL THERAPIST |

**Section 4 – Reason(s) for Referral**

i.e. equipment needs, movement difficulties, safety concerns on playground/inside school, difficulty with stairs. Be specific about impact on school participation.

Primary Concerns of School:

Primary Concerns of Family:

Extra-curricular activities:

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**Section 5 – Pertinent Medical History**

Does this student have a designated disability? Yes ☐ No ☐ Pending ☐

If yes or pending, please check designation: A ☐ B ☐ C ☐ D ☐ E ☐ F ☐ G ☐ H ☐

Please specify medical diagnosis:

Agencies or specialists involved: eg Sunny Hill Health Centre, BC Children's Hospital, Orthopaedic Surgeon, Neurologist, CFA OT etc

Previously:

Current:

Assessment date(s) and findings

**Section 6 (MUST BE COMPLETED)**

☐ The family has been contacted to discuss this referral. They are aware of the school's concerns and have provided their consent to allow the release of this information to VCH.

Date of Referral: _____ Referred by: _____
(School District Representative)

**Instructions for school staff:**

Please send completed form to North Shore Pediatric Resource Team.

Email: **NSPRTphysio@vch.ca** Fax: 604-913-0066