**Sensory Processing Occupational Therapy Referral Form**

*Inclusion Support Team (IST) Use Only*

**Richmond Pediatric Team**

Richmond Public Health

8100 Granville Avenue

Richmond, BC V6Y 3T6

Phone: (604) 233-3150 Fax: 604-233-3198

Have you:

* Reviewed and implemented strategies from the Safe Sensory Strategies Document.
* Connected with the Sensory Processing Occupational Therapist via email with non-identifying student information for further review of strategies (see Sample Questions Document should you be unsure of what to email). If so, on what date? \_\_\_\_\_\_\_\_\_\_\_\_\_

If yes to above 2 bullet points, please continue with completing a referral form to the Sensory Processing Occupational Therapist.

**Process**

1. IST / school team / case manager to discuss referral with parent(s)/ guardian(s)
2. OT referral to be completed and sent to VCH by IST team.
3. VCH will send out a letter to parent(s)/ guardian(s) to inform of referral.
4. OT to contact family to discuss further details regarding assessment and treatment.
5. OT will send out Sensory Profile to referring source and family via email to be completed.
6. OT will book a time for initial observation with school team.

Parent/Guardian has been contacted and given verbal consent for the referral?  Yes  No

***\** Please complete all areas on this form**

1. **General Information:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Referral Date** | Child’s Last Name | | Child’s First Name | | Child’s Preferred Name |
| Personal Health Number | Date of Birth (dd/mmm/yyyy) | | Primary Language(s) | | Interpreter needed? *(no cost)*  Yes  No |
| Gender | Preferred Pronouns | | Preferred Phone Number | | Alternate Phone Number |
| Address (*including city and postal code*) | | | Indigenous Status  Yes  No  Unknown |  | |
| □ Parent / □ Legal Guardian /□ Foster Parent (first and last name) | | | □ Parent / □ Legal Guardian / □ Foster Parent (first and last name) | | |
| Additional Phone Number(s) | | Preferred Pronouns | Additional Phone Number(s) | | Preferred Pronouns |
| Email | | Relationship to Child | Email | | Relationship to Child |

**School Information:**

|  |  |  |
| --- | --- | --- |
| School: | Ministry Designation: | Grade: |
| Classroom Teacher: | | Email: |
| Resource Teacher: | | Email: |
| Education Assistant(s): | | Email: |
| Inclusion Support Team: | | Phone No. & Email: |
| Behaviour Plan:  Yes  No  If yes, please attach | SAFE WORK PLAN:  Yes  No If yes, please attach | IEP:  Yes  No If yes, please attach |

1. **Specialists or Agencies Involved:**

|  |
| --- |
| PROFESSIONAL INVOLVED |

|  |  |  |  |
| --- | --- | --- | --- |
|  | CONTACT PERSON | EMAIL/TELEPHONE | DATE INVOLVED |
| Richmond School District staff involvement (for current year) e.g. SLP, Counsellor, etc  \*Please attach any reports. |  |  |  |
| Home Team e.g. Private OT, PT, SLP, Behaviour Consultant |  |  |  |
| Specialists/Agencies e.g. SHHC/BCCH clinics, Centre for Ability, MCFD Social Worker, CYSN Social Worker |  |  |  |

**Pertinent Medical History (including diagnosis, seizures, medications):**

**Reason for Referral to Occupational Therapy:**

Primary Occupational Therapy goal(s) of the school:

Please check if the child has difficulties in the following areas:

|  |  |  |
| --- | --- | --- |
| behavior\*\* | learning new motor skills | self-regulation |
| attention/ distractible | interacting with others | transitioning to new activities/  locations |
| ability to follow directions | ability to participate in class | other: |

|  |
| --- |
| \*\*\*Describe behavior(s) |

\*\*\* Are there any triggers (sensation, people, locations, etc.) for the behavior?

\*\*\* What helps to calm the behavior?

What items/ toys/ activities are calming for the child?

Displays self-injurious behaviors: Describe:

Current methods to assist with transitioning:

|  |  |  |  |
| --- | --- | --- | --- |
| Visual schedule/prompt | Verbal prompts | Auditory prompts | Physical prompts |
| Clock | “Zones of Regulation” | Fidget toys/sensory activities |  |
| Provide preferred activity / choice | | Other: | |

**Sensory Concerns**

Displays sensory seeking behavior: Describe:

Displays sensory avoidant behavior: Describe:

Appears to under respond to stimuli: Describe:

How is this interfering with school or family goal(s)?:

(A sensory assessment tool, will be sent via email to the referral source. Please complete as soon as possible as this will be needed prior to OT seeing the child)

Does the child currently use any equipment?

Wheelchair  hand splints  toileting equipment  building accessibility  computer access  adapted equipment Other

Does the child demonstrate hand preference?  Right  Left Unknown No preference established

How does the child communicate?

Is child currently performing to grade level in all areas of academic curriculum  Yes  No

If no, what areas are being adapted/modified?

What have you already tried in order to help the student with this concern?

|  |  |  |
| --- | --- | --- |
| What have you tried | How long have you tried it for | What was the result of it (worked/didn’t work) |
|  |  |  |

Form completed by (IST Name):

Contact Information (Phone & Email):       Date:

School Team Members Consulted to Complete this Form:

      Role (i.e. EA, teacher) :

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**Encrypting Emails**

You are welcome to send referrals via e-mail. Because referrals contain personal/health/confidential information, we ask that you send the referral as a password-protected file. To encrypt, please open the referral as a Word document, go to File > Info > Protect Document > Encrypt with a Password. Attach document to email once it is completed and send to OT. Please send the password in a separate email.