Thames Valley Children's Centre

Instructions to Complete a TVCC SLP School Referral

If you have any questions about the referral process, please contact a TVCC Intake Coordinator at 519.685.8716 (in the London calling area) or 1.866.590.8822 ext 58716.

1. Referral packages must be submitted by the school board SLP or Preschool SLP. SLPs can submit referral packages to TVCC for contracted services for students attending publicly funded schools in London, Middlesex, Oxford, Elgin, Huron, Perth, Grey and Bruce counties. (There is one exception: for students attending Osprey Central School in Maxwell in Grey county, referrals are sent to the Children's Treatment Network or CTN). For these services in private schools or in the home, contact your Local Health Integration Network or LHIN.

   The contracted service agencies that will provide these services on behalf of TVCC are assigned by county:
   Elgin, Grey and Bruce counties – Closing the Gap
   Huron and Perth counties – CarePartners and CBI Limited
   London and Middlesex county – St. Elizabeth Health Care and TVCC
   Oxford county – CBI Limited and TVCC

2. Complete the TVCC Family and Community Referral Form. It can be found on the TVCC website separate from this package of school referral forms.

- Students do not require a Health Card to be eligible for service. The space to enter a Health Card number on the form can be left empty.
- In the "Tell us what is needed" box, write if you are requesting SLP services at school.
- If you believe your student would benefit from any of the additional TVCC services outlined on the referral form, please call a TVCC Intake Coordinator to discuss.

3. Complete the SLP Referral Form in this linked referral package. Information typed into the first page will automatically enter into the same field on the following pages.
    - You do not need to attach related reports that are from TVCC; please do refer to them by name and date.
    - Referrals from preschool SLPs do not require a principal signature.

4. Provide the student's legal guardian with the other 3 forms in the linked referral package to be completed by the family.
   - Please support the family to complete their forms if required.
   - If you are unable to obtain written consent and authorization to share information from the student's legal guardian, the school board or preschool SLP can discuss all the information on the forms verbally with the legal guardian and sign all the family forms in the referral package on behalf of the family ie "verbal consent obtained from Bob Smith, legal guardian by Jane Doe, SLP". Before the start of service, the therapist will confirm consent and authorization to share with the family.

5. For students with urgent needs (ie returning to school after surgery with new needs) indicate if the student's needs are urgent from the school perspective on the fax cover sheet. Provide details of the needs on the referral form. TVCC will assess the needs of the student on a priority basis and contact the school and family if there are any questions.

6. To update information about students who are currently waiting for service, you may submit a "Student Update Form" rather than completing a full referral package again. You must discuss with the family (and check on the form that it has been discussed) when you are sharing new information with TVCC. Important updates to share would include any changes to the student's needs or changes to custody or contact information or changes to the school attended. Please share updates about students already receiving service directly with the student's therapist. The therapist will share with TVCC.
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7. **To submit the referral, the SLP** gathers together:
    a. TVCC Family and Community Referral Form
    b. TVCC Public School SLP Referral Package including the SLP Referral Form and the 3 forms from the family
    c. any additional reports

    To form a complete package and submit to TVCC Intake by:
    Faxing to 519.685.8705 OR
    Mailing to:
    Thames Valley Children's Centre, Attention: Intake
    779 Base Line Road East
    London ON N6C 5Y6

You will be contacted by a TVCC Intake Coordinator or Clinical Co-ordinator if we have any questions or require more information. The family and school will be informed if the student is placed on a waitlist for service.

Interim School Therapy Services

SLP Referral Form

To be completed by a Speech Language Pathologist

Student Information:

Name: ______________________ **DOB:** __________

School: ______________________ **School Board:** ______________________

Resource Teacher: ______________________

Background Information (attendance, classroom participation, social interactions and impact of SLP difficulty, etc):

Clinical Observations/Assessment (motivation, attention, behaviour, memory, hearing, language, etc)

☐ see attached report

List or attach any specialized testing completed:

Referring SLP: ______________________ **School Board/PSL:** __________

Signature: ______________________ **Date:** __________

Phone: ______________________ **Ext:** __________

School Principal Authorization: ______________________

(not required for referral from PSL)

*Specify needs and reason for referral on back of page using Program Criteria and Severity Level Definitions for SLP, 2011.

Name: ______________________________ **DOB:** ____________

1. ☐**Articulation/Phonology**

Level of Severity in Connected Speech (Check all that apply)
☐ Occasional sound errors or up to 2 sound errors according to development expectations **(Not eligible)**
☐ 3 – 5 sound errors according to developmental expectations OR Less than 3 sound errors, with concomitant factors (e.g. poor volume control, oral musculature difficulties, increased rate) (Level 3 eligible)
☐ 6 or more sound errors according to developmental expectations (Level 2 eligible)
☐ Speech production more unintelligible than be expected based on results of single word articulation tests
☐ **Motor Speech/Dyspraxia/Dysarthria**
Summary of identified issues: ☐ See attached report

____

____

____

2. ☐ **Fluency**

Level of Severity
☐ 3%-10% frequency of stuttering events. Words stuttered are fleeting, absent or barely visible to casual observer. (**Not eligible**)
☐ 11% - 25% frequency of stuttering events. Words stuttered are noticeable, with a duration of half a second or more. (Level 3 eligible)
☐ >25% frequency of stuttering events. Words stuttered are distracting, with a duration of 3 or more seconds. (Level 2 eligible)
Summary of issues ☐ See attached report

____

____

3. ☐ **Voice/Resonance** ☐ **Post-Surgical SLP Needs**

Parents directed to contact physician for ☐ ENT assessment ☐cleft palate team Date: ____________

Level of Severity ☐ Mild ☐ Moderate ☐Severe
Summary of issues ☐ See attached report

____

____

____

4. ☐ **Swallowing and Feeding**

Past Assessment______________________________ ☐ Unknown
Past Treatment______________________________ ☐ Unknown
Summary of issues ☐ See attached report

____

____

5. ☐ **Non Speech/Augmentative Communication (AC)**

☐ AC needed to express basic needs ☐ Referral to ACS initiated ☐ Involved with ACS
Type of System Used______________________________
Summary of issues ☐ See attached report

____

____

cc: ☐ School Principal to share with school team/OSR

Interim School Therapy Services
Authorization to Share Information

To be completed by the Parent/Legal Guardian or Client:

Please print your full name: ____________________

Please print the full name of the Student: ____________________

Please indicate your relationship to the Student: ____________________

Please check ONE:

☐ I am the legal guardian of the above named child OR ☐ I am the client and am at least 16 years of age.

Services work best when there is good communication among everyone involved with you and your child. I do hereby authorize the exchange of information to and from:

Yes	No	
☐	☐	Thames Valley Children's Centre (TVCC)
AND		
☐	☐	School and School Board, specify both: ____________________
AND		
☐	☐	Preschool Speech and Language Program (if involved) specify: ____________________
AND		
☐	☐	The Service Provider Agency assigned by Thames Valley Children's Centre

The service provider agency that could provide the OT, PT or SLP service at school is determined by the county of your child's school:

Elgin/ Grey/Bruce:	Closing the Gap Healthcare Group
Huron/Perth:	CarePartners or CBI Limited
London/Middlesex:	St. Elizabeth Health or TVCC
Oxford/Norfolk:	CBI Limited or TVCC

AND

☐ ☐ Other: ____________________

Limitation to sharing:

Please indicate below any individual or facility with whom you **DO NOT wish** Thames Valley Children's Centre or School/School Board or Service Provider Agency or Preschool Speech and Language Program staff to communicate. Please indicate the relationship to the client. **If the request is to not communicate with a biological parent please provide supporting documentation.**

Individual/Relationship to the client: ____________________

Confirmation of Referral Receipt:

☐ To save time and postage, please email me and the school the referral confirmation letter. The email will include my child's name, services requested, and assigned urgency of need. My email Address: ____________________

I understand that email is not a private method of communication.

This authorization is valid as long as the above named receives services from Thames Valley Children's Centre. In the event of transfer of services, consent will be valid until one year following inactivation date. This authorization may be cancelled at any time by submitting a written request to Clinical Information Services, Thames Valley Children's Centre.

____________________ ____________________

Signature – Legal Guardian or Client **Date**

Interim School Therapy Services

Consent for Services

To be completed by the Parent/Legal Guardian or Student:

Please print your full name: ____________________

Please print the full name of the child: ____________________

Please indicate your relationship to the child: ____________________

Please check ONE:

☐ I am the legal guardian of the above named child

OR

☐ I am the client and am at least 16 years of age.

By signing this, you are consenting to the start of services which includes the collecting of information to start a clinical record at TVCC. You can access that record at any time. If your child is assigned to another service provider agency for service, that agency will also start a clinical record. The service provider agency that could provide the OT, PT or SLP service at school is determined by the county of your child's school:

Elgin/ Grey/Bruce:	Closing the Gap Healthcare Group
Huron/Perth:	CarePartners or CBI Health Group
London/Middlesex:	ParaMed Home Health Care or St. Elizabeth Health Care or TVCC or VON
Oxford/Norfolk:	CBI Health Group or TVCC

You will be involved in the planning and decisions to be made about how, and if, services continue.

Please check ONE to share your preference below:

☐ I would like the service provider to leave a message informing me when the assessment at school will be started. I understand I will be contacted by the service provider after the completion of the assessment to discuss the assessment findings and a plan for treatment, if applicable.

OR

☐ I would like to have a discussion with the service provider before the therapy assessment at school begins.

____________________ ____________________

Date **Signature of Parent/Legal Guardian or Client**

You can withdraw this consent, therefore ending our services with you/your child, at any time by notifying TVCC Clinical Information Services in writing.

Interim School Therapy Services
Student Background Information Form

Thames Valley Children's Centre

To be completed by Parent/Legal Guardian/Student:

Student Name: ______________________________ **DOB:** ____________

Please give details about the student's medical history: diagnoses, health information, surgeries, services received now or in the past, etc. Please attach any medical reports that may be helpful.

Is the student taking any medications that would affect participation in therapy?

Allergies or Sensitivities:

For safety and to ensure our records are accurate please give details about all allergies (food, medication, latex, environmental, etc.) and sensitivities and indicate that if the allergy is severe and requires an alert made on the client's health record:

Alert Required:

______________________________ ☐

______________________________ ☐

______________________________ ☐

Tell us about the student's needs and equipment:

Does the student have any other special social or behavior or communication needs? ☐ **no concerns**

Student Name: ______________________________ **DOB:** ____________

Is there anything else that would be helpful to know about the student?

Name of Parent/ Legal Guardian/ Client

Date

Signature of Parent/ Legal Guardian/ Client