September 2014

To all Calgary & Rocky View Independent Schools (Private, Charter & ECS)

User Guide to

Calgary and Area RCSD (Regional Collaborative Service Delivery) Independent Schools Referral Pathway 2014-2015

Provincial RCSD Vision: Deliver regional supports and services to enable Alberta's children and youth to succeed in their learning and improve their well-being. Provincial RCSD Goal: Relevant regional supports and services will meet the needs of children and youth in the context of their schools, families, and communities in the most effective and efficient manner possible.
Regional Mission: The Calgary and Area RCSD will engage with families in collaborative cross-sector partnerships to provide timely, equitable, integrated and seamless access to a continuum of supports and services that allow children and youth to be successful at school, at home and in their communities.

This school year, the Calgary and Area RCSD services will be coordinated and integrated within your child's independent school community. The Calgary and Area RCSD services will be tailored to address the student's needs not already being met by school baseline, or other community resources.

Procedure used for completion of forms:

Once the school-based team including the parent/guardian has determined that a referral to the Calgary and Area RCSD is appropriate please check the following:

❑ The Role Description of Regional Service Providers has been reviewed in requesting the appropriate service (page 5).

❑ The teacher/family has completed and signed the Referral Request Form (page 1 - 3) and the principal or designate has co-signed.

❑ The parent/guardian has signed the accompanying Consent to Observation, Assessment and/or Treatment and Consent to Disclosure of Personal Information form (page 4).

❑ School personnel maintain originals in the school file and **fax** (**or scan and email**) a clean clear copy of the **completed package** to the **following contact information**. Send a separate referral form to each service provider from whom you are requesting services.

Contact Information:

Service	Contact
Grade 1-12: Rehabilitation Services Speech-Language Therapy, Occupational Therapy, Physical Therapy, and The PREP Program	**Renfrew Educational Services** **Child Development Centre** **3820 – 24 AVE NW** **Calgary, AB T2E 6S5** **Tel: (403) 291-5038 Fax: (403) 272-1186** **Contact: Joanne Shanks** **Email: joanneshanks@renfreweducation.org**
Grade 1-12: Mental Health Services Mental Health Therapy/Services and COPE	**Family Psychology Centre** **Tel: (403) 282-8288 Fax: (403) 228-9452** **Contact: Debbie Baker** **Email: dbaker@familypsychologycentre.org**
ECS: Rehabilitation Services Speech-Language Therapy, Occupational Therapy and The PREP Program	**Providence Children's Centre** **5232 – 4th Street SW** **Calgary, AB T2V 0Z4** **Tel: (403) 255-5577 Fax: (403) 255-1254** **Contact: Anca Medesan** **Email: amedesan@providencechildren.com**
Low Incidence: (formerly REACH Services) Physical Therapy, Occupational Therapy, Speech-Language Therapy, Vision Consultant, Orientation & Mobility, Educational Audiology, Deaf or Hard of Hearing, Educational Psychology/Behaviour **Renfrew Educational Services will forward referral to the appropriate Calgary and Area RCSD Low Incidence provider.*	**Renfrew Educational Services** **Child Development Centre** **3820 – 24 AVE NW** **Calgary, AB T2E 6S5** **Tel: (403) 291-5038 Fax: (403) 272-1186** **Contact: Joanne Shanks** **Email: joanneshanks@renfreweducation.org**

NOTE: Incomplete Referral Request and Consent forms will be returned and will delay the process.

Calgary and Area RCSD (Regional Collaborative Service Delivery)
INDEPENDENT SCHOOLS
Confidential Referral Request Form 2014-2015

(to be completed by parents and school personnel)

This is an initial referral and there will be additional requests for information upon acceptance.

❑ **New Referral** ❑ **Re-Referral**

PART A: STUDENT IDENTIFICATION:

Last Name: ________________ First Name: ________________ Also Known As: ________________

Date of Birth: ________________ (MM/DD/YR) Female ________ Male ________

Parents/Guardian: ________________ Relationship to Child: ________________

Full Address: ________________

Postal Code: ________________ Home Phone Number: ________________

Mother's Cell Phone Number: ________________ Father's Cell Phone Number: ________________

Mother's Work Phone Number: ________________ Father's Work Phone Number: ________________

Mother's Email Address: ________________ Father's Email Address: ________________

If cultural/language interpreter required, please specify (Cultural/Language/Dialect): ________________

School: ________________ Grade: ________________

Address: ________________ Postal Code: ________________

Times Attending Class: ________ to ________ am; and/or ________ to ________ pm

Special Education Code: ________________ Individual Program Plan (IPP): Yes ________ No ________

Diagnosis: ________________

School Contact (for this referral): ________________ Title: ________________ Best Time to Contact: ________

Telephone: ________________ Fax: ________________ Email: ________________

Classroom Teacher: ________________ Telephone: ________________ Email: ________________

PART B: SERVICE REQUEST (Note: Review and Highlight Description of Service Providers for Parents – page 5):

Please send a separate referral form to each service provider from whom you are requesting services.

- ❑ Occupational Therapy
- ❑ Occupational Therapy (Mental Health) – only accessed after consultation with Mental Health Services
- ❑ Physical Therapy (Grades Only)
- ❑ Speech-Language Therapy
- ❑ Mental Health Therapy/Services (Grades Only)
- ❑ COPE (Kindergarten – Grade 12) – Community Outreach in Pediatrics/Psychiatry & Education Program
- ❑ The PREP Program
- ❑ Low Incidence (formerly REACH) – Please Specify:
  - Physical Therapy
  - Occupational Therapy
  - Speech-Language Therapy
  - Vision Consultant (Ophthalmology report must be attached)
  - Orientation & Mobility (for visually impaired)
  - Educational Audiology (Audiogram must be attached)
  - Deaf or Hard of Hearing (Audiogram must be attached)
  - Educational Psychology/Behavior

Please Note: Only complete the section(s) pertaining to the health service(s) for which you are applying.

PART C: REASON FOR REQUEST FOR SERVICE (TEACHER & FAMILY PERSPECTIVE):

Speech–Language Therapy:	**Parent**	**Teacher**
Child has trouble saying certain speech sounds.	☐	☐
Child is currently being seen by a Speech-Language Pathologist.	☐	☐
Child has trouble understanding questions or following directions.	☐	☐
Child has trouble communicating with other children.	☐	☐
Child has difficulty expressing ideas.	☐	☐
Child has trouble with their vocabulary.	☐	☐
Child has trouble listening and hearing.	☐	☐
Child has difficulty with memory or remembering.	☐	☐
Child has trouble making friends.	☐	☐
Child stutters.	☐	☐
I have concerns about child's voice quality.	☐	☐

Occupational Therapy:	**Parent**	**Teacher**
Child has trouble holding a pencil.	☐	☐
Child has trouble with activities such as colouring, cutting or picking up small objects.	☐	☐
Child has trouble printing.	☐	☐
Child has trouble using both hands together (i.e., cutting, building Lego).	☐	☐
Child has trouble recognizing differences in shapes.	☐	☐
I am concerned about my child's self-help skills (i.e., dressing, feeding, toileting). Please list: ______________________________	☐	☐
Child has sensory-motor difficulties (i.e., hypersensitive or under-reactive, awkward in movement, poor eye-hand coordination, mouth-finger fidgeting, poor activity transitions, unable to calm self, impulsive).	☐	☐
Child has organizational/attention difficulties.	☐	☐

Physical Therapy (Grades Only):	**Parent**	**Teacher**
Child loses his/her balance.	☐	☐
Child has difficulty participating in "chasing" games (i.e., tag).	☐	☐
Child has difficulty recognizing his/her own body parts left to right.	☐	☐
Child has trouble throwing and catching a ball.	☐	☐
Child has difficulty using playground equipment (i.e., slides, swings, low balance beam).	☐	☐

Mental Health Services (Grades Only):	**Parent**	**Teacher**
Child has difficulty coping in the classroom (i.e., attention, conflict, unorganized, attendance, or displays severe inappropriate (aggression) or unsafe behaviour).	☐	☐
Child has difficulty with relationships in the classroom (i.e., making friends, working with adults or peers).	☐	☐
Child exhibits severe emotional behaviour(s) in the classroom (i.e., anger, sadness, or swings in mood).	☐	☐
Child lacks confidence and/or has a very poor self-image, which affects their school performance.	☐	☐
Home disruption/change impacting the child's school performance.	☐	☐

Short-Term Learning Objectives/Goals (Parent/Teacher):

PART C – Continued

Describe what has been tried to meet these concerns. What worked? What didn't work?
(Please indicate the student's strengths as a learner)

Teacher:

Family:

PART D: INFORMATION RELEVANT TO THIS REFERRAL (Please indicate other service providers currently working with this child/family and whether a report is available. Please indicate if relevant reports, IPP's or professional diagnosis are contained within the student's school record):

PART E: REFERRAL REQUEST APPROVAL (This Referral Request Form must be accompanied by the Consent to Observation, Assessment and/or Treatment & Consent to Disclosure or Personal Information - Page 4):

By signing below, I acknowledge that I am in agreement with this referral request to Calgary and Area RCSD for this child.

Parent/Legal Guardian – Please Print	Principal or Designate – Please Print
Signature	Signature
Date	Date

SUBMISSION:
1. Refer to user guide for submission information.
2. **Retain this original in the student's file and fax to:**

Grade 1 – 12: Rehabilitation Services Joanne Shanks Fax: 272-1186	**Grade 1 – 12: Mental Health Services** Debbie Baker Fax: 228-9452
ECS: Rehabilitation Services Anca Medesan Fax: 255-1254	**Low Incidence (formerly REACH)** Joanne Shanks Fax: 272-1186

FOIP STATEMENT

To be able to provide health services to you and/or your family, we need to ask you for some personal information. The Provincial Freedom and Privacy Act protects how your personal information is collected and used. If you have any questions about how your personal information is collected and used, please ask your service provider.

For Calgary and Area RCSD Use Only

Service Provider: ______________________________

Name: ______________________________
Therapist / Health Professional

Date: ______________________________

CONSENT FOR OBSERVATION & ASSESSMENT
CONSENT TO DISCLOSURE OF PERSONAL INFORMATION

Name of Student:	**School:**	**Date of Birth** (DD/MM/YY):

Purpose of this Form

The Calgary and Area RCSD (Regional Collaborative Service Delivery) is made up of education and health organizations coordinating and providing health services to students. This form documents your consent to have staff of the participating organizations in the RCSD program assess your child and to share information about your child in accordance with the *Health Information Act, ss. 34 and 59, Freedom of Information and Protection of Privacy Act, s 38 (1)(c) and the School Act, Student Record Regulation, s. 5(2)(b)(iv).*

Consent for Observation & Assessment
Consent to Disclosure of Personal Information

I authorize the following Calgary and Area RCSD service provider(s) / service(s) to assess my child:

- ❑ **Occupational Therapist**
- ❑ **Physical Therapist** (Grades Only)
- ❑ **Speech-Language Pathologist**
- ❑ **Mental Health Therapist** (Grades Only)
- ❑ **COPE** (Kindergarten to Grade 12)
- ❑ **The PREP Program**
- ❑ **Low Incidence (Please Specify):**
  - ○ **Physical Therapy**
  - ○ **Occupational Therapy**
  - ○ **Speech-Language Therapy**
  - ○ **Vision Consultant**
  - ○ **Orientation & Mobility**
  - ○ **Educational Audiology**
  - ○ **Deaf or Hard of Hearing**
  - ○ **Educational Psychology/Behavior**

Consent to Information Sharing

I authorize organizations participating in the Calgary and Area RCSD to collect and disclose student information and health registration, assessment, diagnostic and treatment information about my child. This information may only be collected and disclosed to Calgary and Area RCSD organizations for the purposes of coordinating and providing services to my child within the Calgary and Area RCSD program and for making referrals to the appropriate care providers. If and when treatment is offered, another Calgary and Area RCSD Service Provider Consent Form for this purpose will be required to be completed. I also authorize organizations participating in the Calgary and Area RCSD to store and access the information in a computer database system for the same purposes (i.e., name, date of birth, school, service requested).

Statement of Understanding

I have had the above consent information explained to me, and all my questions have been answered to my satisfaction. I understand the reasons why the assessment and the information are needed and I am therefore aware of the risks or benefits of consenting or refusing to consent. I also understand that I may revoke this voluntary consent at any time to a Calgary and Area RCSD service provider.

AUTHORIZATION:

❑ **This consent will be ongoing, unless there is a change that affects my child's participation in this program AND this consent expires one (1) year from date of signing, unless consent is withdrawn by the parent/guardian.**

Dated this __________ day of __________________, 201___

______________________________	______________________________
Name of Parent/Guardian (please print)	**Name of Principal/Specialist/Designate (please print)**
______________________________	______________________________
Signature of Parent/Guardian	**Signature of Principal/Specialist/Designate**

The Family Psychology Centre

Registered Psychologists, Mediators, and Family Therapists
Jeff Chang, Ph.D, R.Psych., Director
● phone: (403) 282-8288 ● fax: (403) 228-9452 ●

REFERRAL FORM

Name: ________________________________ School: ________________________
Grade: ____ Date Of Birth: ______________ Alberta Learning No.: ______________
Parents/Guardians: ____
Phone No.: Home: ________________ Parent 1: Work: ______________________
Cell: ______________________
Fax: ______________________
Parent 2: Work: ______________________
Cell: ______________________
Fax: ______________________
E-mail: ____________________ preferred method of contact: ________________

A. Presenting concerns (provide specific behavioral descriptions):

____
____
____
____
____
____
____

B. School history and achievement:

____
____
____
____
____
____
____

C. Family history (in relation to presenting concern):

____
____

D. Student strengths/family strengths:

E. What are the main concerns that you would like to be addressed as a result of this referral?

Parents:

School:

F. Current professional involvement/services (e.g., counsellors, therapists, child welfare, probation, speech/language pathology, occupational therapy, resource teacher, medical specialists):

G. Previous professional involvement (provide dates):

H. Medical condition/diagnosis including medications:

____
____
____
____

I. Previous formal assessments (please obtain and attach):

____
____
____
____

J. I have attached all the following documents:

- ❑ Informed consent of guardian (required for referral to be processed)
- ❑ Available assessments
- ❑ Coding documentation
- ❑ Reports from professionals
- ❑ IPP's

K. **Referring person: (please print):** ______________________________

Signature: ______________________________

The Family Psychology Centre

Registered Psychologists, Mediators, and Family Therapists

Jeff Chang, Ph.D, R.Psych., Director

● phone: (403) 282-8288 ● fax: (403) 228-9452 ●

Consent for Consultation Services

To the parents/guardian of: ____

Your school wishes to refer your child to the Family Psychology Centre for a consultation that will assist the school in serving your child better, and providing or arranging follow-up services.

The following procedures may be used in this consultation:

Consultation Process:

1. Observing your child in the classroom.
2. Reviewing your child's school file
3. Conducting a consultation meeting in which you, school staff, and if appropriate your child discuss the concerns.

At the conclusion of the consultation, you will be provided with a summary of the meeting that will give the recommendations.

Follow-Up Process:

1. Short-term counselling for your child or your family.
2. Referral to ongoing or long-term services
3. Providing advice or consultation to the school.
4. Support to get connected to other services.

Your school can provide you with a brochure describing the consultation service operated by The Family Psychology Centre. If you would like to speak with a Family Psychology Centre staff member, your school can provide you with the contact information.

Cost:

There is no cost for this service, which is funded by the Calgary Rockyview Student Health Partnership. There may be a cost for some follow-up services to which you may be referred. This will be discussed with you before any referral is made.

The Family Psychology Centre:

The Family Psychology Centre is a private psychology firm based in Calgary since 1992. We provide services to individuals, families, schools, employers, government agencies, and the courts. See our website at www.familypsychologycentre.org.

Please refer to www.cap.ab.ca for practice standards applicable to psychologists.

Consent Section:

My name is ______________________________________, and I am the legal guardian of ______________________________. I authorize The Family Psychology Centre to undertake this consultation with my child _____________________________.

If my child is subject to a final order with respect to custody or access under the Divorce Act (Canada) or the Family Law Act (Alberta), I certify that this order authorizes me to consent on my child's behalf.

If any interim order exists, The Family Psychology Centre requires that both parents consent to this consultation and follow-up services. I have attached a copy of the latest Order.

I have had any questions about these services answered to my satisfaction. I acknowledge that I can revoke my consent at any time.

_____________________________________ _____________________________________

Signature of Parent/Guardian *Date*

____

Signature of School Official (witness)