ST. JAMES-ASSINIBOIA SCHOOL DIVISION **IJNB-E**

CONFIDENTIAL

#228018

EDUCATIONAL SUPPORT SERVICES

1 Braintree Crescent, Winnipeg, Manitoba R3J 1C7 Phone: 885-1334 Fax: 885-7594

REQUEST FOR ASSISTANCE

- **All signatures required prior to submission**
- **Scan form to Educational Support Services and place original in green clinical file.**
- **Provide copy to parent/guardian.**
- **Processed form will be returned electronically to School Administrative Assistant to be printed and placed in file.**

School_____ MET No. _____Teacher _____Date_____

Name_____ DOB _____ Identifies as: _____ Grade_____
Last Name First Name *MM/DD/YY*

Address_____ PC_____ Phone No _____

Guardian _____ Relationship: _____

Work No: _____ Cell No: _____ Email: _____

Guardian _____ Relationship: _____

Work No: _____ Cell No: _____ Email: _____

Address (if different from above): _____

Legal Guardian_____

Child resides with_____

Siblings (name, age, school) _____

Language/s spoken in home (if other than English)_____

Other schools attended and grades (if known) _____

ACADEMIC INFORMATION (academic strengths and weaknesses, specific disabilities, or grades repeated)
Attach source report if appropriate.

RELEVANT HEALTH AND SOCIAL INFORMATION

Vision: Date screened_____ Does student require glasses Yes ☐ No ☐

Hearing: Date screened_____ Normal ☐ Loss ☐

Medication _____

Name of family physician _____ Address_____

Other significant medical information_____

Currently known to other agencies ☐ Please specify_____

_____

PERTINENT FAMILY INFORMATION _____

_____

Is attendance a concern? Yes ☐ No ☐

If yes, give details _____

REMEDIAL ACTION TAKEN BY SCHOOL:

Guidance ☐ Reading Recovery ☐ Resource ☐ 8 Step Response/Safety Plan ☐
Other ☐ Please specify_____

REASON FOR REFERRAL: Case open to: ***(all case opening clinicians to sign after consultation & prior to submission of referral)***

	Social Work		Certified Reading Clinician
	Psychology		Consultant for Deaf and Hard of Hearing
	Speech/Language		Occupational Therapy
	Physiotherapy		

Case Manager:_____ Position: _____

Educational Support Services offers specialized help to students and their families. The services are provided by teams comprised of Social Workers, Psychologists, Speech/Language Pathologists, Physiotherapists, Occupational Therapists, Certified Reading Clinicians, Consultants for the Deaf & Hard of Hearing, and Behaviour Team. One or more of the above clinicians may become involved in assisting with specific needs. Information will be shared with you. We work closely with school personnel and provide them with verbal and written information to assist in the programming and delivery of school-based interventions. Statistical information may be collected on a periodic basis. All identifying information is kept confidential.

☐ ***I have read and understand the information above and give my consent for clinician involvement. I am aware that I can withdraw consent at anytime.***

I consent to the referral. _____ _____
Guardian's Signature or Client if over 18 **Date**

_____ _____
Signature of Person Making Request Principal's Signature

FOR OFFICE USE ONLY

Date received by E.S.S.: _____ **CLEVR Entry Date: _____**

I understand that my child's personal information and personal health information will be kept confidential and protected in accordance with FIPPA and PHIA. I understand that any other collection, use or disclosure of personal or personal health information about my child will not be permitted without my consent, unless authorized under FIPPA or PHIA. If you have any questions or concerns about the collection of this information, contact the Access and Privacy Officer at the St. James-Assiniboia School Division, 2574 Portage Avenue, Winnipeg, MB R3J 0H8, telephone (204) 888-7951