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

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

Section 2 – Parent(s)/Guardian Information (PLEASE PRINT)		
NAME OF PARENT OR GUARDIAN (FIRST AND LAST) ☐ Mother ☐ Father ☐ MCFD SW	HOME TELEPHONE WORK TELEPHONE	EMAIL
NAME OF PARENT OR GUARDIAN (FIRST AND LAST) ☐ Mother ☐ Father ☐ MCFD SW	HOME TELEPHONE WORK TELEPHONE	EMAIL
Language spoken in home	Is English understood? ☐ Yes ☐ No	STUDENT RESIDES WITH ☐ Parent(s) ☐ Other caregiver (Name)

Section 3 – School Information (PLEASE PRINT)		
SCHOOL NAME	GRADE	☐ LEARNING SUPPORT TEACHER or ☐ 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, signed form to North Shore Pediatric Resource Team.

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