School District 78
Fraser-Cascade

650 Kawkawa Lake Road, Hope, B. C. V0X 1L4
Phone (604) 869-2411
Fax (604) 869-7400

District Referral Form
Student Support Services

Student: _____

Address: _____

_____

Grade: _____ Birthdate: _____

School: _____

Parent/Guardian: _____

Telephone No.: _____

First Language: _____

Support Services Required
Speech/Language Therapist _____
Child Care Counsellor _____
Psychoeducational Assessment _____
**Must complete parent and school forms
ELL/ESD _____
Other _____

Dates and Results of last:
Hearing Screening _____
Vision Screening _____
Pertinent Medical Reports _____

Current Ministry designation _____

1. *Describe school-based intervention(s) already in place. Attach criterion-referenced assessment and pertinent classroom-based assessments.*

_____
_____
_____
_____

2. *Reason for referral? What does the school-based team hope will happen as a result of this referral?*

_____
_____
_____
_____

3. *Other agencies/school personnel involved:*

_____
_____
_____
_____

_____
Referred by

_____
Principal/Designate Signature

_____
Date of Referral

_____
Support Services Specialist Signature

_____
I understand and approve of this referral.
Parent/Guardian Signature