COWICHAN VALLEY
School District

REFERRAL FORM: SCHOOL PSYCHOLOGIST

To gain more information about and to support the learning of the student named below, the School Based Team (SBT) wishes to submit a referral for school psychologist consult and/or psychoeducational assessment to Inclusive Learning Review Team. *(Referral form is completed by SBT Program Manager and reviewed by Principal and Legal Guardian(s) prior to signing).*

Student Legal Name:		**D.O.B:**	
School:		Grade:	
Classroom Teacher(s):			
SBT Case Manager:		**The SBT Program Manager is the important link between School Staff, SBT, Legal Guardians, the Student, and District School Psychologist.**	

Listed below are **All Legal Guardians** & Dates **of Contact/Discussion** of the Psychoeducational process by SBT Program Manager (*Please indicate all dates and whether the discussions were by phone or in person*).

	Dates:	
	Dates:	

Below is a list of pertinent information the SBT will share with the District Administration Referral Review Team in preparation for initiating an assessment.

Reason the SBT wants more information about the student's academic, cognitive, behavioral, emotional, and/or adaptive functioning:

Student Strengths:

Student Struggles:

Date of Recent Vision Assessment		Outcome:		Has Glasses: Yes ☐ No ☐
Date of Recent Hearing Assessment		Outcome:		

Special Education Services (OT, PT, SLP, Counsellor, ELL) and Dates Accessed.	
Attendance Record (past three years)	2021-2022:_____ 2022-2023:_____ 2023-2024:_____
Current Accommodations and Adaptations	
Current Diagnoses/Designations	
Current Medications	
Dates and Results of Prior Assessments (including SLP, OT, and Psychological Assessments; as well as District Learning Inventories, CBM, Level B assessments).	
Interventions completed (including length of time, focus, and years of academic or social emotional support by LART staff or counsellors).	
Family or Life Conditions that may invalidate an assessment (e.g. had a Psychoeducational Assessment in the past two years, had a recent change in medication, recent trauma, recent surgery such as eye surgery etc.)	

SIGNATURES of AGREEMENT: The SBT wishes to submit the referral for a Psychoeducational Assessment for the student named below.		
Student Legal Name:		DOB:
Classroom Teacher(s):	*Signature/Print Name of Classroom Teacher*	Date:
SBT Program Manager:	*Signature/Print Name of Case Manager*	Date:
Principal:	*Principal Signature/Print Name of Principal or Vice Principal*	Date:

Legal Guardian(s): *Guardian(s) Signature of Consent / Print Name Guardian(s)*	Date:

Legal Guardian(s): *Guardian(s) Signature of Consent / Print Name Guardian(s)*	Date: