Revised: November 2024
Form # ST.02.15

Bloorview SCHOOL AUTHORITY

Return to: registration@bloorviewschool.ca
or
Bloorview School Authority
150 Kilgour Road Toronto ON M4G 1R8
Tel: 416-424-3831 Fax: 416-425-2981

Integrated Education and Therapy (IET) at Bloorview School
Applicant Information from Referring Source
To be completed together with the parent/guardian

REFERRING SOURCE INFORMATION
The Application Committee may contact the referring source as well as the child's therapists as part of the application process.

Referral initiated by: _____ Phone Number: _____		Date:
Form completed by:		

APPLICANT INFORMATION

Child's Name: First _____ Last _____ Child's Date of Birth: D/MMM/YYYY	Primary Diagnosis: _____ All other diagnoses:	
Parent's/Guardian's Name:	Parent's/Guardian's Name:	
Address:		Postal Code:
Email Address:	Home Phone:	Cell Phone:
Child is followed by a HBKRH physician. HBKRH Chart #:	HBKRH Physician's Name:	
Child is followed by Children's Treatment Network. CTN#		
First language spoken at home: _____ Interpreter required for parent communication with school: Yes ☐ No ☐		

HEARING AND VISION NEEDS

Hearing	**Vision**
Hearing Aids Yes ☐ No ☐	Glasses Yes ☐ No ☐
Followed Regularly Yes ☐ No ☐ By whom: _____	Followed Regularly Yes ☐ No ☐ By whom: _____

OTHER MEDICAL NEEDS
If this child is accepted to Bloorview School we will collect all relevant medical data at the time of registration.

CRITERIA
Please answer all the following questions. The child:

Requires a multidisciplinary approach for education and therapy?	Yes ☐ No ☐
Demonstrates complex needs in **two or more** of the following areas?	
• Physiotherapy, Occupational Therapy, Speech and Language Therapy	Yes ☐ No ☐
Has received these services in the past year: ☐ Speech and Language Therapy ☐ Occupational Therapy ☐ Physical Therapy	
Is an active client of HBKRH or Children's Treatment Network (CTN) in York Region?	Yes ☐ No ☐
Is a resident of Toronto or York Region?	Yes ☐ No ☐
Will be of Kindergarten or Grade 1 age by December 31st, 2025 (born 2021, 2020, 2019)	Yes ☐ No ☐
Has the ability to tolerate a full day in a classroom setting?	Yes ☐ No ☐
Can attend to a range of different activities for 3-5 minutes?	Rarely ☐ Sometimes ☐ Always ☐
List at least three examples of activities the child enjoys:	
Indicates Yes by: Smiling ☐ Consistent Sound ☐ Nodding ☐ Word ☐ Sign ☐ AAC ☐ Not yet ☐	
Indicates No by: Crying ☐ Pushing Item Away ☐ Consistent Sound ☐ Shaking Head ☐ Word ☐ Sign ☐ AAC ☐ Not yet ☐	
Is able to make a consistent clear choice between two or more: Words ☐ Objects ☐ Real Photos ☐ Picture Symbols ☐ Choice is not yet consistent ☐	

COMMUNICATION/LANGUAGE

Speech and Language Pathologist's Name:	Phone Number:

How would you rate the need for Speech Language therapy? Active ☐ Monitor ☐ None ☐

Child has demonstrated the ability to integrate skills taught in therapy into daily activities? Rarely ☐ Sometimes ☐ Always ☐

Current Speech and Language service: Consultation ☐ Active Blocks ☐ Waitlist ☐ None ☐

Please list current speech and language goal(s):

Please respond to all that apply:	The child communicates using: Body movement ☐ "Home" signs/gestures ☐ Single words/approximations ☐ 2-4 words ☐ Full sentences ☐ Picture Symbols ☐ Speech generating device ☐

Can the child demonstrate understanding in their home language of:

Single step directions without a gesture Rarely ☐ Sometimes ☐ Always ☐

Familiar words (e.g. eat, more, all done, go, hands, feet) Rarely ☐ Sometimes ☐ Always ☐

OCCUPATIONAL THERAPY SKILLS

Occupational Therapist's Name:	Phone Number:

How would you rate the need for Occupational Therapy? Active ☐ Monitor ☐ None ☐

Child has demonstrated the ability to integrate skills taught in therapy into daily activities? Rarely ☐ Sometimes ☐ Always ☐

Current Occupational Therapy service: Consultation ☐ Active Blocks ☐ Waitlist ☐ None ☐

Please list current occupational therapy goal(s):

PHYSICAL THERAPY SKILLS

Physiotherapist's Name:	Phone Number:

How would you rate the need for Physiotherapy? Active ☐ Monitor ☐ None ☐

Child has demonstrated the ability to integrate skills taught in therapy into daily activities? Rarely ☐ Sometimes ☐ Always ☐

Current Physiotherapy service: Consultation ☐ Active Blocks ☐ Waitlist ☐ None ☐

Please list current physical therapy goal(s):

ADDITIONAL REMARKS

Please provide any additional information to support the referral to the IET program. This could include, but is not limited to, the responsiveness of the child to therapy, specific gains in therapy, and overall school readiness.

CONFIRMATION OF PARENT/GUARDIAN INVOLVEMENT

Is the family aware of this referral: Yes ☐ No Have you seen the family in the last year: Yes ☐ No	Referring Source Signature:

Signed application and release of information consent form must be received by January 17, 2025.
Email to: registration@bloorviewschool.ca