SCHOOL DISTRICT NO. 48

♦ *Squamish* ♦ *Whistler* ♦ *Pemberton*

REQUEST FOR STUDENT SUPPORT SERVICES
CROSS REFERRAL

Student's Name: _____
Last / First

Date of Birth: _____ Gr. _____
Year / Month / Day

Parent(s): _____

Phone/Cell: _____

School: _____

Date: _____

Parent(s) Address: _____

_____

Email: _____

❑ ❑
Yes No A Comprehensive referral form for District Special Services has been completed for your child within the previous year.
(If no; Please complete comprehensive "blue" referral instead)

Consultation with District Specialists and school Special Education Staff support the following additional Special Services:

- ❒ Speech/Language
- ❒ Academic/Ed.Psych. Assessment
- ❒ Counselling (Elementary)
- ❒ Vision Impairment Services
- ❒ Low Incidence Support Team (School Psychologist signs for LIST)
- ❒ Behaviour/Attention
- ❒ Deaf & Hard of Hearing
- ❒ Occupational Therapy (School Psychologist signs for service)
- ❒ Physical Therapy (School Psychologist signs for service)
- ❒ MIST (Multi Interdisciplinary Support Team Observation) (School Psychologist Initial Here: _____)

Reason for referral: _____
_____
_____

You will be informed of the results. If you have any additional questions or would like further information, please contact the school.

Principal	Date	District Staff Rep.	Date
L.A./Resource Teacher	Date	District Staff Rep.	Date
Classroom Teacher	Date	District Staff Rep.	Date

I give consent for the above services to be carried out on behalf of _____
(Full name of child)

Parent/Guardian _____ Date _____

Note: Cross-Referrals are to be initiated by District Specialists

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