



500 Hallmark Drive Waterloo, Ontario N2K 3P5 (519-886-8886)
 250 Hespeler Road Cambridge, Ontario N1R 3H3 (519-621-7580)
 (c/o Chaplin Family YMCA)

REQUEST FOR CONSULTATION
SPOT PROGRAM

Please complete all sections fully. Incomplete forms may result in delays in processing.

Important:
 All SPOT referrals must be initiated by calling the Special Needs Access Point (SNAP) at 741-0076.
 Date of referral to SNAP: _____

I. CHILD IDENTIFICATION

Child's Last Name: _____ **First Name:** _____

Date of Birth: _____

II. CHILD CARE CENTRE

Childcare Centre Name: _____

Referred By: _____

Telephone: _____

FOR HOME CHILD CARE USE ONLY

Provider's Name: _____
 Address: _____
 Telephone No.: _____

Attendance (at childcare program)

M T W Th F AM PM Full Day

I am referring this child for:

Speech-Language Consultation	<input type="checkbox"/>
Physiotherapy Consultation	<input type="checkbox"/>
Occupational Therapy Consultation	<input type="checkbox"/>

III. REFERRAL STATEMENT

(To be completed by childcare staff)

Describe the child's speech, language, physical and/or behavioural difficulties:

Explain how these difficulties influence his/her participation in your program:

PARENT INFORMATION

The remainder of this form is to be completed by the child's parent or guardian, or with the assistance of the teacher / case worker.

Parent Information Completed By: _____

IV. PARENT'S STATEMENT OF THE DIFFICULTY

Describe what you see as your child's speech, language and/or physical difficulty if different from childcare's concerns.

V. GENERAL DEVELOPMENT / MEDICAL HISTORY

Were there any unusual problems during pregnancy, birth or infancy?

If yes, please describe: _____

Does your child have any medical problems, chronic conditions, allergies, or limitations to physical activity that we should know about before he/she is assessed or suggestions are given?

At what age did your child:

Sit	_____	Use single words	_____
Walk	_____	Combine words	_____
Toilet train	_____		

Are there any family members who have or had speech, language, hearing and/or physical problems?

If yes, please explain: _____

Have you been involved/are you currently involved with KidsAbility? _____

What services did you/do you receive there? _____

Name of Family Doctor: _____ Telephone: _____

Other Doctors/Specialists/Investigations: _____

Has your child's vision been tested? _____

When, by whom and with what results? _____

VI. SPEECH, LANGUAGE AND HEARING DEVELOPMENT

****Please complete if requesting speech-language consultation.**

What languages are spoken in the home? _____

Has your child had ear infections? _____ If so, how many? _____

Has your child seen an Ear, Nose and Throat (ENT) Doctor? _____

If so, who? _____ When? _____

Has your child's hearing been assessed? _____ When, by whom and with what results? _____

Does your child understand what you are saying? _____

What does your child prefer to use?

- | | | | |
|--------------------------|------------------|--------------------------|--------------------|
| <input type="checkbox"/> | Gestures | <input type="checkbox"/> | Sounds |
| <input type="checkbox"/> | One or two words | <input type="checkbox"/> | Complete sentences |

Can other people understand your child? _____

VII. PHYSICAL DEVELOPMENT

**** Please complete if requesting physiotherapy or occupational therapy consultation.**

Is your child able to:

- | | | | |
|-----------------------------|-------|-------------|-------|
| Use a ride-on toy | _____ | Kick a ball | _____ |
| Ride a tricycle | _____ | Play catch | _____ |
| Climb stairs independently | _____ | Finger feed | _____ |
| Dress/undress independently | _____ | Use a spoon | _____ |

Does your child:

- | | |
|---|---------------|
| - avoid certain materials/textures (e.g. messy play, scratchy, rough) | Please Circle |
| - avoid touch from others (e.g. hugs, hand-over-hand help) | Yes / No |
| - cover their ears or react to certain noises | Yes / No |
| - comment on noises you don't hear | Yes / No |
| - avoid <u>or</u> prefer certain tastes or food textures (e.g. salty vs sweet; soft vs crunchy) | Yes / No |
| - demonstrate a high activity level; fidgeting even when they sit | Yes / No |
| - avoid activities involving movement (e.g. swings, slides) | Yes / No |
| - react negatively to <u>or</u> crave certain smells/odours | Yes / No |

Please indicate any additional information you feel will help us in understanding your child:

VIII. PARENTAL CONSENT

I agree to:

- the assessment of my child’s skills as requested on Page 1
- the verbal sharing of the results of my child’s assessment with the Childcare staff at a conference scheduled after the completion of the assessment
- the sharing of written report(s) and programs with the Childcare staff

I understand that I am encouraged to attend the conference but, if I am unable to attend, the meeting will proceed in my absence.

_____ Date

_____ Parent/Guardian

_____ Date

_____ Witness

<p>Please fax <u>or</u> mail this form to the: S.P.O.T. Coordinator, KidsAbility 500 Hallmark Drive, WATERLOO, Ontario N2K 3P5 Telephone No: 886-8886 Fax: 886-7292</p>
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