

COMPLEMENTARY SERVICES REQUEST

STUDENTS

DATE OF REQUEST: _____	TEACHER TO CONTACT: _____
------------------------	---------------------------

REQUEST FOR WORKSHOP (CLASS) – please specify below	
<input type="checkbox"/> Level: _____	<input type="checkbox"/> Subject: _____

***** OR *****

REQUEST FOR FOLLOW-UP* (STUDENTS) – please specify with which service(s) below			
<input type="checkbox"/> Psychoeducation	<input type="checkbox"/> Guidance Counselling	<input type="checkbox"/> Speech Pathology	<input type="checkbox"/> Orthopédagogie
<input type="checkbox"/> Social Work	<input type="checkbox"/> Psychology	<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Other: _____
<p>For a request for FOLLOW-UP, please forward this form by email to Educational Services at se@csdulittoral.qc.ca accompanied by the documents listed on the right.</p>		<input type="checkbox"/> Student Identification Form (following page) <input type="checkbox"/> Signed Consent Form <input type="checkbox"/> Request Analysis Questionnaire (if 1 st request) <input type="checkbox"/> Most Recent Report Card <input type="checkbox"/> Most Recent Intervention Education Plan <input type="checkbox"/> Any Other Pertinent Documents	

***** OR *****

REQUEST FOR ASSESSMENT* (STUDENTS) – please specify with which service(s) below			
<input type="checkbox"/> Psychoeducation	<input type="checkbox"/> Guidance Counselling	<input type="checkbox"/> Speech Pathology	<input type="checkbox"/> Orthopédagogie
<input type="checkbox"/> Social Work	<input type="checkbox"/> Psychology	<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Other: _____
<p>For a request for ASSESSMENT, please forward this form by email to Educational Services at se@csdulittoral.qc.ca accompanied by the documents listed on the right.</p>		<input type="checkbox"/> Student Identification Form (following page) <input type="checkbox"/> Signed Consent Form <input type="checkbox"/> Request Analysis Questionnaire (if 1 st request) <input type="checkbox"/> Most Recent Report Card <input type="checkbox"/> Most Recent Intervention Education Plan <input type="checkbox"/> Summary of Interventions Done by the School (Orthopédagogie, Special Education, etc.) <input type="checkbox"/> All Professionals' Reports on File, If Applicable <input type="checkbox"/> All Medical Reports on File, If Applicable <input type="checkbox"/> Any Other Pertinent Documents	

* All Complementary Services Request submitted by the school is not systematically approved. Each request is analyzed by the clinical committee based on the documents provided by the school team. The final recommendation may be different from the one issued by the school team. The request may also be refused.

Principal's Comments and Clarifications:

Signature of Principal: _____

Date: _____

COMPLEMENTARY SERVICES REQUEST

STUDENT IDENTIFICATION FORM

INFORMATION ON STUDENT

FIRST NAME(s)	LAST NAME(s)	GENDER	DATE of BIRTH
		<input type="checkbox"/> M <input type="checkbox"/> F	

PERMANENT CODE	SCHOOL	LEVEL	YEAR	TEACHING LANG.
		<input type="checkbox"/> Prim. <input type="checkbox"/> Sec.		<input type="checkbox"/> French <input type="checkbox"/> English

NAME and LAST NAME of PARENT 1	NAME and LAST NAME of PARENT 2

FAMILY STATUS – THE STUDENT LIVES WITH:	LANGUAGE(s) SPOKEN at HOME
<input type="checkbox"/> Both Parents <input type="checkbox"/> Parent 1 <input type="checkbox"/> Parent 2 <input type="checkbox"/> Shared Custody <input type="checkbox"/> Foster Family <input type="checkbox"/> Other (specify): _____	<input type="checkbox"/> French <input type="checkbox"/> English <input type="checkbox"/> Other (specify): _____

MOTIVE(s) for the REQUEST

<input type="checkbox"/> Learning Difficulties	<input type="checkbox"/> Relational/Social Difficulties	<input type="checkbox"/> Emotional Difficulties
<input type="checkbox"/> Speech Difficulties	<input type="checkbox"/> Concentration/Attention Difficulties	<input type="checkbox"/> Behavioural Difficulties
<input type="checkbox"/> Motor/Sensory Difficulties	<input type="checkbox"/> Other (specify): _____	

INFORMATION ON STEPS ALREADY TAKEN

The parents have been contacted: by phone in writing in person (meeting)

An Individualized Education Plan (IEP) is in place for this student: YES NO If YES --> date of IEP: _____

Precisions and Comments (if there is no IEP in place, please specify the adaptation measures or other strategies implemented):

Services Already Involved	Name	Report/Notes on File?	Date of FIRST Intervention	Date of LAST Intervention
<input type="checkbox"/> Psychoeducation		<input type="checkbox"/>		
<input type="checkbox"/> Social Work		<input type="checkbox"/>		
<input type="checkbox"/> Guidance Counselling		<input type="checkbox"/>		
<input type="checkbox"/> Special Education		<input type="checkbox"/>		
<input type="checkbox"/> Orthopédagogie		<input type="checkbox"/>		
<input type="checkbox"/> Psychology		<input type="checkbox"/>		
<input type="checkbox"/> Occupational Therapy		<input type="checkbox"/>		
<input type="checkbox"/> Speech Pathology		<input type="checkbox"/>		
<input type="checkbox"/> Youth Protection		<input type="checkbox"/>		