



Low-Incidence Service Request

SWRCSD Office: 3305 – 18 Avenue North, Lethbridge, AB T1H 5S1

CHILD/YOUTH INFORMATION	Last Name:	First Name:	Grade:
	Date of Birth: <small>(mm/dd/yyyy)</small>	Program Unit Funding (PUF): <input type="checkbox"/> Yes	
	School:	Teacher:	

PARENT/ LEGAL GUARDIAN INFORMATION	Last Name:	First Name:	<input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian
	Address:	Cell:	Work:
	Email:		
	Last Name:	First Name:	<input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian
	Address:	Cell:	Work:
	Email:		

REFERRER'S INFORMATION	<input type="checkbox"/> Parent/Guardian <input type="checkbox"/> AHS <input type="checkbox"/> School Division <input type="checkbox"/> Community Agency Date: <small>(mm/dd/yyyy)</small>		
	Organization:		
	Referrer's Name:	Phone:	Ext
	Title:	Email:	
	(For schools only) This request has been discussed with the school Administrator <input type="checkbox"/> No <input type="checkbox"/> Yes		

The referrer has obtained informed consent from the parent or legal guardian for this request No Yes

<input type="checkbox"/> Requesting support regarding HEARING concerns Complete yellow column	<input type="checkbox"/> Requesting support regarding VISION concerns Complete blue column
Hearing assessment helpful but not required. <input type="checkbox"/> Audiogram attached	Vision report required , attach either: <input type="checkbox"/> Ophthalmology report <input type="checkbox"/> Optometry report
The child/youth: <input type="checkbox"/> Has been diagnosed with a hearing loss <input type="checkbox"/> Wears amplification: <input type="checkbox"/> Cochlear Implant <input type="checkbox"/> Hearing Aid <input type="checkbox"/> Uses an alternative communication system: <input type="checkbox"/> American Sign Language <input type="checkbox"/> Signed Exact English <input type="checkbox"/> PODD Book <input type="checkbox"/> Communication device <input type="checkbox"/> Other <input type="checkbox"/> Has an interpreter	The child/youth: <input type="checkbox"/> Is legally blind/registered with CNIB <input type="checkbox"/> Has recently experienced vision loss <input type="checkbox"/> Has a reduced field of vision <input type="checkbox"/> Has limited visual acuity <input type="checkbox"/> Has low vision <input type="checkbox"/> Is having difficulty with orientation and mobility <input type="checkbox"/> Needs assistive technology (ex. magnifier) <input type="checkbox"/> Needs appropriate reading and writing media (ex. large print, braille, audio)

Reason for request:

The child/youth:

- | | |
|---|--|
| <input type="checkbox"/> Frequently asks for things to be repeated | <input type="checkbox"/> Is struggling academically |
| <input type="checkbox"/> Struggles to communicate/engage with peers | <input type="checkbox"/> Struggles to follow directions/answer questions |
| <input type="checkbox"/> Has a peer group at school | <input type="checkbox"/> Has difficulty telling a story |
| <input type="checkbox"/> Struggles to communicate with teacher / EA | |

Child/youth strengths and interests:

What strategies have been tried?

What strategies are the most effective?

Instructions to submit form electronically:

1. Complete and save this form
2. Complete Consent for Service/Release of Information document and have parent/guardian
3. Scan consent, attachments/reports (reminder: vision report is required, audiogram is optional)
4. Email documents to:
 - Your Central Office designate AND
 - SWRCSD Low Incidence Team at office@swrcsd.ca