possibilities
science • support • synergy

Teacher Referral Form

After completing please fax to
1•833•482•8999

1. Please provide an email address in the Contact Information area

2. Instead of this form, consider using our online Teacher e-Referral Form.

Contact Information

Student's Last Name: _____

Student's First Name: _____

Student's DOB: (YYYY/MM/DD): _____

Parent/Guardian Last Name: _____

Parent/Guardian First Name: _____

Cell Phone: _____

Alternate Phone: _____

Address: _____

City: _____ Postal Code: _____

Email: _____

We are a virtual-first clinic with secure video sessions available across Ontario, along with some in-person options. Our specialized multidisciplinary services and integrated treatments involve allied health professionals are not covered by OHIP. Fees may be covered by private insurance.

Areas of Concern

Areas of concern have been observed in the following areas:

Academics	Behaviour	Emotion regulation	Social functioning
☐ Reading (speed, accuracy and or comprehension)	☐ Focusing on work and lessons	☐ Transitioning easily from one task to another	☐ Resolving conflicts
☐ Writing (composition)	☐ Working independently	☐ Settling down after upset or disappointment	☐ Initiating conversation
☐ Spelling	☐ Thinking before acting/speaking	☐ Enjoying new learning	☐ Taking turns
☐ Math	☐ Managing time and meeting deadlines	☐ Seeking assistance when needed	☐ Using language to communicate
☐ French Language Learning	☐ Expressing involuntary sounds or motor movements	☐ Persevering in the face of challenge	☐ Participating in social activities and group work

Referring Teacher:_____

School:_____

Phone:_____ Fax:_____

I acknowledge that I have received consent from the family of the above-named patient to share this information with the Possibilities Clinic.

Teacher's Signature: _____ Date: _____

Please type or sign name