



***NEW* Special Needs Access Point Referral Package**

In order to provide better service and reduce the steps required for intake, it is not necessary to phone SNAP to refer a child. Below is the **process** for making a referral.

- 1. Discuss your concerns with the child's parent or guardian.**
- 2. Tell the parent about the services available through the Special Needs Resourcing Collaborative.** Follow the information sheet found on page 2 of this package. Take the time to describe the various services offered and the role of each of the special needs resourcing agencies within licensed child care programs. It is important that the parent/guardian understands that their child may receive support from one or more of the special needs resourcing agencies. **Give the parent the information sheet to keep as a reference.**
- 3. The Consent to Share Information and Referral and Intake Form must be completed by the referral source together with the parent/guardian.**
 - **The Consent to Share Information** is required to complete the referral to the appropriate agency(s). Carefully review the consent with the parent/guardian to ensure they understand the information and services they are consenting to.
 - **The Special Needs Access Point Referral and Intake Form** must be completed with the parent/guardian to ensure accuracy and that they are fully aware of all information documented.
 - For **Re-referrals to SNAP**, complete a new consent form and the SNAP Re-Referral form located on the KWH-SNAP website.
- 4. Fax or mail the completed consent and referral form to:**




Resource Coordinator, Special Needs Access Point
KW Habilitation
99 Ottawa St. S.
Kitchener, Ontario
N2G 3S8
Fax: 1-888-801-7627

The SNAP Resource Coordinator will review the referral form to determine which service(s) will be most beneficial in supporting the child and will forward the referral to the appropriate agency(s). The referral source and parent/guardian (with consent) will receive confirmation via email of the services that have been coordinated.

If you have questions or need assistance please contact the SNAP Resource Coordinator at:
519-514-7627

Special Needs Resourcing Services in Waterloo Region

A partnership funded by the Region of Waterloo’s Children’s Services that ensures all children and their families can fully participate in quality, inclusive Early Learning and Child Care.

 <p>Special Needs Access Point</p>	 <p>Early Learning, Child Care and Family Resources</p>
<p>A single point of access for referrals to services and supports for children in licensed child care including:</p> <ul style="list-style-type: none"> • Developmental screening • Service coordination • Information and resources for families 	<p>Resource Consultants provide support for children with developmental and/or social-emotional concerns including:</p> <ul style="list-style-type: none"> • Developmental screening • An individualized plan to support the child’s development • Service coordination • Ongoing consultation and monitoring • Additional program support for children with complex needs • Information, training, and resources for educators and families
 <p style="text-align: right;">SPOT Program</p>	
<p>Physiotherapy: assesses trunk control, balance, physical abilities in the classroom and on the playground, muscle power, joint stiffness. Assessment of muscle tone involves the therapist moving the legs through the range of motion.</p> <p>Occupational Therapy: assesses play, social and hand skills (eg. Scissor and pre-printing skills), attention to task, sensory processing, and self–help skills (e.g., dressing, feeding, toileting).</p> <p>Kinesiology: assesses the physical environment and suggests enhancements, assists child with physical skill development, promotes safe and active participation for all children.</p> <p>Speech Language Pathology: assesses voice, fluency (e.g., stuttering), resonance (e.g. movement of air through the nose), sound production, oral motor skills, feeding, expressive language, comprehension, and social communication.</p>	



Consent to Share Information

The Special Needs Access Point (SNAP) represents a group of agencies that support children in licensed child care programs in Waterloo Region. All referrals to the services listed below must be processed through SNAP in order to activate service. The following agencies could provide service to children in any licensed child care program:

- KW Habilitation - Special Needs Access Point (SNAP)
- KW Habilitation – Early Learning, Child Care and Family Resources
- KidsAbility – (Speech-Language Pathology/Occupational Therapy/Physiotherapy/Kinesiology)

I, _____ give my consent for my child _____, born on, _____, to be referred to one or more of the agencies listed above.

I acknowledge the following by signing below:

- I have been informed of the role these services may play in meeting my child's needs.
- The SNAP Referral Form will be shared with the appropriate agency (s) listed above.
- My child's skills and development will be screened or assessed by the appropriate agencies listed above. KidsAbility assessments (if applicable) will be scheduled at the child care location to observe and assess my child's development either in the group or individually in a separate, quiet space with fewer distractions.
- Verbal and/or written information, assessments, and reports will be shared between the relevant agencies listed above and with my child's early learning program for the purposes of planning and implementing an individualized program for my child
- Information collected is used to respond to my child's needs, refer to appropriate services and provide data for planning and evaluation
- I understand I have the right to refuse my consent for the participation of any of the agencies at any time.

I consent to receive email communication from the appropriate agency(s) listed above to schedule appointments or confirm referrals made. **Yes** **No**

Signature (Parent/Guardian)

Date

Signature (Witness)

Date



KW Habilitation Special Needs Access Point

Referral and Intake Form

(Phone) 519-514-7627 (Fax) 1-888-801-7627

This form must be completed by the referral source and parent together. Do not send this form home with the parent to complete.

1. Referral Source and Contact Information

Date of Referral: ____/____/____ Referred by: _____
MM DD YY Name and Job Title

ELCC/Agency: _____ Phone/Ext: _____ Email: _____

2. Child and Family Information

Child's Name: _____ M F Child's D.O.B.: ____/____/____
First last MM DD YY

Address: _____ City: _____ Postal Code: _____

Child lives with: _____
(Name and relationship to child)

Custodial parent/guardian: Both Parents Other _____

Parent/Guardian Name: _____ Relationship to child: _____

Address same as child; if different please provide address below:

Address: _____ City: _____ Postal Code: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Parent/Guardian Name: _____ Relationship to child: _____

Address same as child, if different please provide address below:

Address: _____ City: _____ Postal Code: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Languages Spoken: English Other _____ Interpreter Required:

3. Child Care Information

Registered on OneList: Yes No

Child care subsidy required: Yes No Unsure Application completed

This section completed by referral source when the child is ATTENDING a child care program)

Name of licensed ELCC: _____ Classroom: _____

Or

Name of licensed home child care provider: _____

Address: _____ City: _____ Postal Code: _____

Phone number: _____ Email: _____

Home Child Care Consultant: _____ Phone number: _____

Name of Resource Consultant currently supporting licensed program: _____

Days of week child attends: Mon Tues Wed Thurs Fri

Full Days Mornings Afternoons

When did the child start at this location? _____

4. Birth History

Is your child adopted? No Yes, age at adoption: _____

Full Term Premature _____ weeks gestation Baby's weight at birth _____

Were there any concerns during pregnancy or delivery? No Unknown Yes, please describe:

How much alcohol, recreational or prescription drugs were consumed during the pregnancy?

Were there any concerns with your baby's health after birth? No Yes, please describe:

Was the baby in intensive care after birth? No Yes, please describe:

5. Medical History

Family Doctor _____
Date of last visit _____

Specialist (s) _____
Date of last visit _____

Pediatrician _____
Date of last visit _____

Other Practitioner (s) _____
Date of last visit _____

Does your child have a diagnosis? No Yes, please describe: _____
Diagnosed by: _____

Does your child have asthma? No Yes, please describe: _____

Does your child have allergies? No Yes, please describe: _____

Has your child's vision been tested? No Yes, date of exam/results _____

Has your child's hearing been tested since one year of age? No
 Yes, date of exam/results: _____

Has your child had recurring ear infections? No Yes, please describe: _____

Has your child seen an Ear, Nose and Throat doctor? No Yes, date seen/results: _____

Does your child have tubes in his/her ears? No Yes Date of surgery: _____

Has your child been hospitalized or had any surgeries since birth? No Yes, please describe:

Does your child require ongoing medication? No Yes, please describe: _____

6. Family Information

Please describe any family history of medical, learning, mental health or developmental concerns:

Please list anyone else who lives in the home (e.g. siblings, parents, grandparents, aunt, etc.)

7. Developmental Information

Please describe why you are seeking support through special needs resourcing services in your child care program:

Considering the child's developmental age, please provide a detailed overview of the **child's interests and strengths along with developmental concerns for each area** as discussed by the referral source and parent together. To ensure timely processing of referrals and access to appropriate services **all sections must be completed**. The examples provided in each section are for reference only.

Communication Skills:

Describe the child's use of communication skills (i.e. size of vocabulary, sentence length, difficulty with pronunciation for age, stuttering, making requests and responding to questions, difficulty with understanding of language, following directions, avoids eye contact)

Cognitive Skills:

Describe the child's understanding and problem-solving skills (i.e. awareness of concepts such as big/little, awareness of body parts, problem solving with toys/activities, emerging pre-academic knowledge such as colours/shapes/numbers/letters, attention span during tasks and play)

Play Skills:

Describe the child's play skills (i.e. engagement in activities, turn taking and sharing, pretend/imaginary play, play interests, play is developmentally appropriate/purposeful)

Gross Motor:

Describe the child's movement and mobility (i.e. transitions in/out of positions, tripping/falling, mobility, balance, difficulty accessing or reluctance to engage in physical activity using areas of playground, gym, caregiver home or classroom, activity level compared to peers, child has an injury/disability requiring temporary modification to environment or adaptive equipment)

Fine Motor:

Describe the child's engagement in fine motor activities (i.e. manipulative toys, puzzles, drawing, crafts, use of scissors, ability or difficulty using one or both hands in play)

Self-Help Skills:

Describe the child's self-help skills (i.e. dressing/undressing, toileting, brushing teeth, washing/drying hands)

Feeding Skills:

Describe the child's feeding skills (i.e. difficulty breast/bottle feeding, growth/weight concerns, transitioning to solids, managing textures, gagging, choking, overstuffing mouth, drooling, eats only 2-3 food items, texture avoidance/preference, use of feeding utensils)

Social/Emotional:

Describe the child's social/emotional wellbeing (i.e. separation from parent/caregiver, transitions, self-regulation, aggression, self-injury, peer and adult interactions, interest/play with peers or appears to avoid/prefer to play alone, withdraws from activities, difficult or harmful childhood experiences, history of trauma)

Sleeping:

Describe the child's sleep routine (naps/bedtime/wake time) and indicate if the child has a history of sleep difficulties (i.e. falling asleep, waking often, apnea, snoring, does not appear rested)

Sensory:

Describe the child's ability to use their senses and respond to their world (i.e. does child use their senses well, exhibit repetitive behaviours or exaggerated responses to sensory stimuli, seek or avoid particular sensory inputs such as noise/taste/smell/visual/tactile/movement)

What are you currently doing in the child care setting and/or at home to support the child's success

8. Other Services Involved

No other services involved

Agency	Service	Name of Contact	Status: Active, Waiting, Closed
Developmental Services Resource Centre (DSRC)	<input type="checkbox"/>		
Family and Children's Services	<input type="checkbox"/> Family Services Worker		
	<input type="checkbox"/> Child Protection Worker		
Carizon/Lutherwood	<input type="checkbox"/> Zero 2 Six		
	<input type="checkbox"/> Front Door		
KidsAbility	<input type="checkbox"/> Speech Language Pathology		
	<input type="checkbox"/> Occupational Therapy		
	<input type="checkbox"/> Physiotherapy		
	<input type="checkbox"/> Kinesiology		
	<input type="checkbox"/> Autism Services		
	<input type="checkbox"/> Social Work		
K-W Habilitation	<input type="checkbox"/> Resource Consultant		
	<input type="checkbox"/> Psychology Services		
Region of Waterloo	<input type="checkbox"/> Infant and Child Development Program		
	<input type="checkbox"/> Healthy Babies, Healthy Children Program		
Waterloo Wellington Local Health Integration Network (WWLHIN)	<input type="checkbox"/> Care Coordinator		
	<input type="checkbox"/> Physiotherapy		
	<input type="checkbox"/> Occupational Therapy		
	<input type="checkbox"/> Speech Language Pathology		
	<input type="checkbox"/> Nursing		
	<input type="checkbox"/> Nutrition		
KW Extend-a-Family	<input type="checkbox"/>		
Vision Loss Rehabilitation Ontario	<input type="checkbox"/>		
Other (i.e. private IBI, private therapy(s), psychology, etc.)	<input type="checkbox"/>		
	<input type="checkbox"/>		
	<input type="checkbox"/>		

Has your child had a private (fee for service) assessment for:

- Speech Physiotherapy Occupational therapy Psychology

Name of private therapist/psychologist _____

Date of assessment: _____

Additional comments/concerns *(to be completed by the parent/guardian)*

Additional comments/concerns *(to be completed by the referral source)*

Please fax or mail this form to the:

**Resource Coordinator, Special Needs Access Point
KW Habilitation
99 Ottawa St. S.
Kitchener, Ontario
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Fax: 1-888-801-SNAP (7627)**

Questions can be directed to Resource Coordinator, Special Needs Access Point by calling **519-514-7627** or by email to snap@kwhab.ca

