DEAF AND HARD OF HEARING CONSULTANT TEAM—REFERRAL FORM

Note: Download and save the form to your digital device, complete it using Adobe Acrobat, and submit it by email.

Student Information

Last Name _____ First Name _____ DOB (D/M/Y) _____

Parent(s)/Guardian(s) _____ Home Phone (____)_____ Work Phone (____)_____

Address _____ City _____ Province _____ Postal Code _____

Cell Phone (____)_____ Email _____

Languages Spoken at Home and Mode of Communication _____

Manitoba Education and Early Childhood Learning Consultant _____

Agencies Involved ❑ Manitoba Possible ❑ CSHC ❑ Other (list): _____ Audiologist _____

Additional Medical/Physical Conditions: _____

_____

School Information

School _____ Grade _____ School Division _____

Address _____ City _____ Province _____ Postal Code _____

Phone (____)_____ Fax (____)_____ Principal _____ Principal's Email _____

Contact Person/Case Manager _____ Position in School _____

Contact Person's Email _____

Division Staff Involved (e.g., Resource Teacher, Speech/Language Pathologist, Teacher of the Deaf/Hard of Hearing, Psychologist, etc.)

_____

Reason(s) for Referral to Team: _____

_____

_____

_____

PLEASE NOTE: A copy of the student's most recent AUDIOLOGICAL REPORT must accompany this referral.

Parent/Guardian Signature _____ Date _____

Principal Signature _____ Date _____

Student Services Administrator Signature _____ Date _____

PLEASE SEND this completed form along with the audiological report and the completed Consent to Indirect Collection and Disclosure of Personal Information form to:

Deaf and Hard of Hearing Consultant Team
Inclusion Support Branch
204–1181 Portage Avenue
Winnipeg, Manitoba, Canada R3G 0T3 OR by fax: 204-948-3229
OR by email: Robynne.Taypaywaykejick@gov.mb.ca

Manitoba

Manitoba
Education and Early Childhood Learning
Student Achievement and Inclusion Division
Inclusion Support Branch
211–1181 Portage Avenue, Winnipeg, Manitoba, Canada R3G 0T3
T 204-945-7907 **F** 204-948-2501
www.edu.gov.mb.ca/k12

CONSENT TO INDIRECT COLLECTION AND DISCLOSURE OF PERSONAL INFORMATION AND PERSONAL HEALTH INFORMATION BY MANITOBA EDUCATION AND TRAINING (DEAF AND HARD OF HEARING SERVICES UNIT)

The Deaf and Hard of Hearing Services Unit (the "Unit") may need to collect and disclose your child's personal information and personal health information in order to give consultative support to schools providing programming for your child.

Your consent is requested so that the following personal information and personal health information about your child can be indirectly collected and disclosed by the Unit under the authority of *The Freedom of Information and Protection of Privacy Act, (C.C.S.M. c. F175) (FIPPA) and The Personal Health Information Act, C.C.S.M.c. P33.5 (PHIA):*

- speech development,
- language development,
- hearing and listening development, and
- health, intellectual, emotional and social conditions that may impact learning.

Consent

I consent to the persons and entities indicated below disclosing personal information and personal health information about my child to the Unit to support my child's school in providing appropriate programming to my child:

This information may be collected from and/or disclosed to the following names/agencies:

❑ School (name): _____ ❑ Manitoba Possible/CCC ❑ Central Speech and Hearing Clinic

❑ Audiologist (name): _____ ❑ Other (please name): _____

❑ Agency Outside of Manitoba (name):_____

I consent to the Unit collecting my child's personal information and personal health information from these persons and entities, and to the Unit disclosing such personal information to these persons and entities as may be necessary to obtain the information the Unit requires from them and for the purpose of supporting my child's school in providing appropriate programming to my child.

I understand that:

I have the right to withdraw my consent at any time by notifying the Unit. My consent cannot be withdrawn retroactively. My consent continues until I notify the Unit that I withdraw my consent.

The persons and entities referred to above that will collect and disclose my child's personal information and personal health information will be instructed not to use or disclose the information, except for the purposes noted above.

The personal information and personal health information received by the Unit will be kept in a confidential file and access to the information will be limited to individuals working to support my child (for example: Education Consultant, Spoken Language Consultant, ASL/Education Consultant, Education Interpreting Consultant, or others as appropriate).

Child's Name and Date of Birth (please print) _____

Signature of Parent/Guardian _____ Date _____

If you have any questions about this form or the collection of information, please contact 204-945-7912