CENTRALIZED INTAKE GENERAL REFERRAL FORM

KENORA & RAINY RIVER DISTRICTS – VOLUNTARY CHILDREN'S SERVICES

FOR REFERRALS OF CHILDREN/YOUTH TO CENTRALIZED INTAKE FOR THE FOLLOWING PARTNER AGENCIES:

- Child and Community Resources (Ontario Autism Program)
- FIREFLY (All services)
- Kenora Association For Community Living (Children's Serv. only)
- Kenora & Rainy River Districts Child and Family Services (Children's Mental Health + Developmental Services only)
- Kenora Chiefs Advisory (Developmental Services only)
- Northwestern Health Unit (North Words Preschool SLP Program)
- Sioux Lookout First Nations Health Authority (Develop. Services only)

NON-URGENT REFERRALS ONLY

MANDATORY SECTION:

Youth/Parent/Guardian Signature: _____ Date: _____

OR: *Referring Party has spoken* ***directly*** *to client/parent/guardian to discuss this referral and has received* ***verbal consent*** *to initiate this referral. -->* **Referring Party's Initials:** _____

Name/role of referring party: _____ Date: _____

Agency/School: _____ Phone: _____

Email address: _____ Fax: _____

Child's Name: _____ (First) _____ (Last) Date of Birth: _____ MMM _____ DD _____ YYYY

Anishinaabe Name: _____ Clan: _____

Gender: _____

Preferred Pronoun: ☐ he/him/his ☐ she/her/hers ☐ they/them/theirs ☐ xe/xem/xyrs ☐ ze/zer/zers ☐ ze/zie/hir/hirs

Health Card: _____ (# + Version Code)

EMHWare #: _____ (FIREFLY Agency use only)

Status Card #: _____

NOTE: **WE CANNOT ACCEPT REFERRALS WITHOUT THIS INFO FOR CLIENTS FROM FAR NORTH COMMUNITIES**

Band Name: _____

Preferred Language: ☐ English ☐ French ☐ Indigenous

Interpreter Required? _____ *(If yes, for what language)*

Physical Address: _____

Mailing Address: ☐ (Check if same as previous) _____

NOTE: A complete mailing address (PO Box, City & Postal Code) is extremely importing for sending correspondence regarding this referral

Please Note: *If this is a self-referral from a youth aged between 12-15.99 yrs of age, the referring party should attempt to encourage the child/youth to involve their parent/guardian in this process, to ensure best possible outcomes.*

- If this referral is directly from a Child/Youth 12 years or older, do they give permission for FIREFLY to involve their parent(s) in the ☐ Yes ☐ No
- **If No,** please include best method(s)/time for contacting the youth: _____

Please submit the fully completed form to our Central Intake Toll Free Fax Line at 1-866-470-1783

Child or Youth's Name	Date of Birth (Month/DD/YYYY)
	,

Parent/Caregiver: _____ Relationship to Child: _____

Physical Address:
(if different than youth's) _____

Mailing Address: ☐ (Check if same as previous) _____

Home Phone: _____ Cell: _____ Daytime #: _____

What is the preferred method to contact the family? _____

If family/client does not have phone, OK to leave non-detailed message at: _____ Description: _____
(phone number)

*If the child's caregiver (listed above) is **not** his/her legal guardian, or the child is in the care of a Child Welfare agency:*

Agency Name: _____ Agreement Type: _____

Worker's Name: _____ Phone: _____

Email Address: _____ Fax: _____

School Information: Does this child have an IEP? ☐ No ☐ Yes

School/Child Care Centre: _____ Grade: _____

The following section is for School use only: *all other agencies/professionals continue to* **Referral Selections:**

☐ *Please check here if this client is being referred from **School Board Counselling to Agency-Provided Children's Mental Health Counselling**.*

☐ *Please check here if referral is for **School-Based Rehabilitation Services** **Note: Effective Jan 1, 2019***
If yes, please also attach required screening questionnaires (download at http://www.fireflynw.ca/access-to-services) and any previous assessments/reports from the child's OSR).

☐ SBRS Occupational Therapy ☐ SBRS Physiotherapy ☐ SBRS Speech Language Pathology

☐ Section 23 (FIREFLY, Transitions North, Spark)

Referral Selections: Identify which program(s) the child is being referred to:

*Please Note: The following services can all be **requested for consideration**; however the client's suitability/eligibility for some programs will be determined by their respective agencies and cannot be guaranteed.*

☐ Infant/Child Development (0-6 yrs)
☐ Child/Youth Development (6 yrs +)
☐ Children's Mental Health
☐ Speech Language Pathology (0-6 yrs)
☐ Speech Language Pathology (6 yrs +)
☐ Occupational Therapy
☐ Physiotherapy
☐ Service Coordination/Family Navigator
☐ Bi-Cultural Coordinator
☐ NW Autism Diagnostic Hub
☐ Fetal Alcohol Spectrum Disorder Assessment
☐ FASD Support Worker
☐ Respite Services
☐ Psychometry/Psychology/Psychiatry
☐ Integrated Transition Planning (14 yrs +)
☐ Ontario Child & Youth Tele-Mental Health (Telepsychiatry)
☐ SNAP (Stop Now and Plan) Program
☐ Specialized Seating/Mobility (George Jeffrey CC)
☐ Augmentative Communication (George Jeffrey CC)
☐ ABA Behaviour Consultation – Fee for Service

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Child or Youth's Name	Date of Birth (Month/DD/YYYY)

Reason for Referral: Please provide a brief description of the problem/concern
(To assist in the referral process, if the client consents, please also attach any relevant medical, psychological, rehabilitation, behavioural assessments and reports etc., including those that identify a previous diagnosis)

If referring for Fetal Alcohol Spectrum Disorder Clinic, is there confirmed alcohol consumption during pregnancy? ☐ Yes ☐ No ☐ Suspected ☐ Unknown

Other Service Providers, Agencies, Physicians, Community Resources Involved? Please list as many as possible:

Does the client/family require any assistance or accommodations in order to participate in a **telephone meeting** with an Intake worker? (ie. Access to a telephone, Wheelchair Accessibility, documents in large type or Braille, modified speed and volume of speech, specific appointment scheduling to allow for regular medical routines etc). *If yes, please have the client/family member describe what accommodations would best assist them:* ☐ No

Does the client/family require any assistance or accommodations in order to participate in **any future services** the client/family may select after the intake meeting is completed? (ie. Wheelchair Accessibility, documents produced in large type or Braille, access to text-to-speech software, specific appointment scheduling to allow for regular medical routines, meetings held in their own home etc.) ☐ No

Any other information that is important or helpful regarding this referral?

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