# Firefly-FC

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|  | **CENTRALIZED INTAKE**  **GENERAL REFERRAL FORM** |

# *Kenora & Rainy River Districts – Voluntary Children’s Services*

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| ***for referrals of children/youth to centralized intake for the following partner agencies:*** | |
| * Child and Community Resources (Ontario Autism Program) | * Kenora Chiefs Advisory (Developmental Services only) |
| * FIREFLY (All services) | * Northwestern Health Unit (North Words Preschool SLP Program) |
| * Kenora Association For Community Living (Children’s Serv. only) | * Sioux Lookout First Nations Health Authority (Develop. Services only) |
| * Kenora & Rainy River Districts Child and Family Services (Children’s Mental Health + Developmental Services only) | |

***NON-URGENT REFERRALS ONLY***

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| ***MANDATORY SECTION:*** | | | | | | | | | | | |  |
| Youth/Parent/Guardian Signature: | | | |  | | | | Date: | Click or tap to enter a date. | | |  |
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| ***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:*** | | |  | |  |
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| Name of referring party: | | | | |  | | | | Date: | Click or tap to enter a date. | | | | | |  |
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| Agency/School: | | | | |  | | | Phone: | |  | | | | | |  |
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| Email address: | | | | |  | | | | Fax: |  | | | | | |  |
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| **Child’s Name:** | | |  | | | | | | | | | | | |  | |  | | | | | | | | | | | |  | | | Date of | |  | | |  |  |  |  | |  |
|  | | | *(First) (Last)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | Birth: | | | *MMM* | | |  | *DD* |  | *YYYY* | |  |
| Anishinaabe Name: | | | | | |  | | | | | | | | | | | | | | | | | | | | Clan: | | | |  | | | | | | | | | | | |  |
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| Gender: |  | M | | | | |  | | | F | | |  | | | | Declined | |  | | | Unknown | | | | | | | | |  | | Other: | |  | | | | | | |  |
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| Health Card: | | |  | | | | | | | | | | | | | | | | |  | | | | | EMHW#: | | | | |  | | | | | | | | | | |  |  |
|  | | | *(# + Version Code)* | | | | | | | | | | | | | | | | |  | | | | | (FIREFLY Agency use only) | | | | | | | | | | | | | | | |  |  |
| Status Card #: | | |  | | | | | | | | | | | | | | | | |  | | | Band | | | | | | |  | | | | | | | | | | | |  |
|  | | | ***NOTE:* WE CANNOT ACCEPT REFERRALS WITHOUT THIS INFO FOR CLIENTS FROM FAR NORTH COMMUNITIES** | | | | | | | | | | | | | | | | |  | | | Name: | | | | | | |  | | | | | | | | | | | |  |
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| Preferred | | |  | | English | | |  | | | French | | | | |  | | Indigenous | | | Interpreter | | | | | | | | |  | | | | | | | | | | | |  |
| Language: | | |  | | | | | | | | | | | | | | | | |  | | | Required? | | | | | | | *(If yes, for what language)* | | | | | | | | | | | |  |
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| Physical Address: | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
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| Mailing Address: | | | |  | | | (Check if same   as previous) | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
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| ***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 intake process? |  | Yes |  | No |
| * **If No**, please include best method(s)/time for contacting the youth: | | | | |
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| **Child or Youth’s Name** | **Date of Birth (Month/DD/YYYY)** |
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| **Parent/Caregiver:** | | |  | | | | | | | | | | Relationship to Child: | | | | | | |  | | | |  |
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| Physical Address:  (if different than youth’s) | | | |  | | | | | | | | | | | | | | | | | | | |  |
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| Mailing Address: | |  | | (Check if same  as previous) | |  | | | | | | | | | | | | | | | | |  | |
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| Home Phone: |  | | | | | | |  | | Cell: |  | | | |  | | | Daytime #: | | |  | | |  |
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| What is the preferred method to contact the family? | | | | |  | | | | | | | | | | | | | | | | | | |  |
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| If family/client does not have phone, OK to leave non-detailed message at: | | | | | | |  | | | | |  | | Description: | | |  | | | | | | |  |
|  | | |  | | | | (phone number) | | | | |  | | | |  | | |  | | |  | | |

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| *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:* | | | | | | | | |
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| Agency Name: |  |  | Agreement Type: | | | |  |  |
|  |  |  |  | | | |  |  |
| Worker’s Name: |  | | | | Phone: | |  |  |
|  |  |  |  | | | |  |  |
| Email Address: |  | | |  | | Fax: |  |  |
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| **School Information:** | | | Does this child have an IEP? | | |  | No | | |  | Yes | | | |  |
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| School/Child Care Centre: | | |  | | | | | | | | | | Grade: |  |  |
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|  | **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 | | |
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|  | **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 |
|  | | Autism Assessment/Services |  | 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 (*Kenora only*) | | |  | Specialized Seating/Mobility (George Jeffrey CC) | | |
|  | | Augmentative Communication (George Jeffrey CC) | | |  |  | | |

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| **Child or Youth’s Name** | **Date of Birth (Month/DD/YYYY)** |
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| **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)* | | | |
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| **Other Service Providers, Agencies, Physicians, Community Resources Involved? Please list as many as possible:** | | |
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| 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 | | |
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| 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 | | |
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| Any other information that is important or helpful regarding this referral? | | |
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