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| Firefly-FC | **CENTRALIZED INTAKE** **GENERAL REFERRAL FORM** |

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| *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)
 | * 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-CRISIS REFERRALS ONLY***

If you are the cargiver of a child/youth requesting Children’s Mental Health services, please consider assisting the child/youth to complete the **Online Self-Referral** form to speed up their Intake process; <https://fireflynw.ontarionow.ca/self-referral/>

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| ***MANDATORY SECTION:***  |       |  |
| Youth/Parent/Guardian Signature: |  | 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 & role of referring party: |       | Date: |       |  |
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| Referrer Agency/School: |       | Phone: |       |  |
|  |  |  |  |  |  |
| Mailing & Email address: |       | Fax: |       |  |
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| **Child’s Name:** |       |  |       |  | Date of |      |  |    |  |      |  |
|  |  *(First) (Last)* | Birth: | *MMM* |  | *DD* |  | *YYYY* |  |
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| Anishinaabe Name: |      | Clan: |       |  |
|  |  |  |  |  |
| Band Name: |       |  |  |  |
| Gender: |       |  |  |
| Pronouns: | [ ]  | he/him/his | [ ]  | she/her/hers | [ ]  | they/them/theirs | [ ]  | xe/xem/xyrs | [ ]  | ze/zer/zers |  |
|  | [ ]  | ze/zie/hir/hirs | [ ]  | she/they | [ ]  | he/they | [ ]  | Specify: |       |  |
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| Health Card: |       |  | Ontario Autism Program #: |       |  |  |  |  |
|  | *(# + Version Code)* |  | *(Required if referring forOAP programs)* |  |  |  |  |  |  |
| Preferred Language: | [ ]  | English | [ ]  | French | [ ]  | Indigenous  | InterpreterRequired? |      |  |
|  |  |  |  | *(If yes, for what language)* |  |
| Physical Address: |       |  |
|  |  |  |  |  |  |
| Mailing Address: | [ ]  | (Check if same  as physical) |       |  |
| ***NOTE: A complete mailing address (PO Box, City & Postal Code) is extremely important for sending correspondence regarding this referral*** |

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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 physical) |       |  |
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| Home Phone: |       |  | Cell: |       |  | Email: |       |  |
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| What is the preferred method/ time 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: |       |  |
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| Worker’s Name: |       | Phone: |       |  |
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| Email Address: |       |  | Fax: |       |  |
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| **School Information:** | Does this child have an IEP?  | [ ]  | No | [ ]  | Yes |  |
|  |  |  |  |  |
| 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*** *If yes, please also attach required screening questionnaires (download at* [*https://www.fireflynw.ca/get-help-now/*](https://www.fireflynw.ca/get-help-now/) *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) |  |  |
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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. Note: Service options vary by community.* |
| [ ]  | 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 |
| [ ]  | Planning for Adult Dev Services (14+) | [ ]  | Fetal Alcohol Spectrum Disorder Assessment | [ ]  | FASD Support Worker |
| [ ]  | Psychology/Psychiatry | [ ]  | Pediatrician Clinic | [ ]  | Respite Services |
| [ ]  | Augmentative Communication  | [ ]  | Feeding/Swallowing Assessment | [ ]  | Specialized Seating/Mobility |
| [ ]  | NW Autism Diagnostic Hub | [ ]  | OAP/Autism Urgent Response\**(\*****Note:*** *these referrals also require the Urgent Response Screen Tool be* *submitted)* | [ ]  | ABA Behaviour Consult - Fee for Service |
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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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|  **If referring for Fetal Alcohol Spectrum Disorder Clinic, is there confirmed alcohol consumption during pregnancy?**  |
| [ ]  | Yes | [ ]  | No | [ ]  | Suspected | [ ]  | Unknown |  |
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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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