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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: | |  | | | | | |  |
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| 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: | | | | |  | | | | | | | | | | | | | | | |  |
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| 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 for OAP programs)* | | | | | | | | | | | | | | |  | | |  | |  | | | |  | | | | | | |  | |  |
| Preferred Language: | | | | | |  | | English | | |  | | French | | | | | | |  | | Indigenous | | | | | InterpreterRequired? | | | | | | |  | | | | | | | | | | | | | | | |  |
|  | |  | | | | | | | | | | | | | | | | | | | | |  |  | | | | | | | | | | *(If yes, for what language)* | | | | | | | | | | | | | | | |  |
| Physical Address: | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
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| 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: | | | |  |  |
|  |  |  |  | | | |  |  |
| 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 | | | | | | |  |
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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*** *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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