# Ontario Autism Program (OAP) Urgent Response Service (URS)

Supplemental Referral Information

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| --- | --- | --- | --- | --- | --- |
| **Child’s Name:** |  |  | **Date of Birth:** |  |  |
|  | *(First + Last Name)* |  |  | *(MMM DD, YYYY)* |  |
| **Person Completing Referral:** |  |  | **Agency:** |  |  |
|  |  |  |  |  |  |
| **Referent Contact Email:** |  |  | **Contact**  **Phone:** |  |  |
|  |  |  |  |  |  |

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| **Date URS Referral submitted:** | | |  |  | **Child/Youth’s OAP #:** | | |  | |  |
|  |  | | | *(if # not yet received/available complete next section)* | |  |
|  | | | *(MMM DD, YYYY)* |
|  | |  | | |  |  |  | |  | |
| ***(Select One)*** |  | Child has been referred to OAP but not assigned an OAP registration number yet  | |  | **Date Client was referred to OAP:** | | |  | |  |
|  |  | |  |  | | | *(MMM DD, YYYY)* | |  |
|  | Caregiver unsure if OAP referral has been made; however, person/agency listed here may be of assistance in determining if referral to OAP was completed  | |  | **Contact Name and/or Agency who may be of assistance:** | | |  | |  |
|  |  | |  |  | | | | |  |
|  | Child has not yet been referred to OAP  | |  | ***Note:*** *This child will not qualify for OAP Urgent Response services; however, Service Navigation assistance will be provided if referring professional is not able to provide this service (e.g. medical professionals)* | | | | |  |

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| Briefly Describe Reason for Referral to OAP Urgent Response Service: |
| Comments: |

**\*Note:** Clients experiencing an imminent/significant Mental Health Crisis  
should be referred immediately to locally available **Crisis Services** *before* referring for Urgent Response:

|  |  |
| --- | --- |
| **Child/Youth Name:** | **DOB:** |
|  | September 22, 2019 |

Company name

Description automatically generated

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| **Please list any coexisting diagnoses with Autism. This information may be helpful when designing the service plan and identifying appropriate referral options.** |
| Additional Diagnoses: (ADHD, Intellectual Disability, etc.) OR Query of another diagnosis? None/Not applicable |

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| **Behaviours**  Please check if the child/youth demonstrates any of the following behaviours:  (*check all that apply*) | **When did this behaviour begin to occur or worsen**? |
| **Aggression towards others**  No  If yes, select occurrence timeframe  | Choose an item. |
| Comments: |
| **Non-Suicidal Self-Injurious Behaviour**  No  If yes, select occurrence timeframe  | Choose an item. |
| Comments: |
| **Risk of Exploitation (bullying, internet safety risk)**  No  If yes, select occurrence timeframe  | Choose an item. |
| Comments: |
| **Flight Risk (bolting, running away)**  No  If yes, select occurrence timeframe  | Choose an item. |
| Comments: |
| **Suicidal Ideation/Suicidal Behaviour**  \*Note: Clients experiencing an imminent/significant Mental Health Crisis should be referred immediately to locally available Crisis Supports or taken to local hospital for stabilization.  No  If yes, select occurrence timeframe  | Choose an item. |
| Comments: |
| **Violent Thinking**  No  If yes, select occurrence timeframe  | Choose an item. |
| Comments: |

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| **Behaviours cont’d** | **When did this behaviour begin to occur or worsen?** |
| **Fire Setting** (preoccupation with fire, fire setting behaviour)  No  If yes, select occurrence timeframe  | Choose an item. |
| Comments: |
| **Harm to Animals**  No  If yes, select occurrence timeframe  | Choose an item. |
| Comments: |
| **Inappropriate Sexual Behaviour**  No  If yes, select occurrence timeframe  | Choose an item. |
| Comments: |
| **Property Destruction**  No  If yes, select occurrence timeframe  | Choose an item. |
| Comments: |

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| Family Coping |
| Does the family struggle to cope when the identified behaviour or situation occurs? |
| Yes  No |
| If yes, please describe impact on family: |

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| **What is the family hoping to achieve through participating in the Urgent Response Service?** |
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| **Medical:** | |
| Has a medical cause (ie. tooth ache, migraines, back pain etc) for the high-risk behaviour been ruled out?  Yes  No | |
| Date of child’s/youth’s most recent medical checkup? | |
| **Please include any additional information you feel is relevant:** | |
|  | |
| **The child/youth has the following assessments or reports available to inform the plan:**  ***\*\*Please include with referral*** | |
| Coordinated Service Plan (most recent document)  Psychological Assessment/Report  Occupational Therapy Assessment/Report  Speech/Language Therapy Assessment/Report | Psychiatry Report (Tele-Mental Health Consult, etc.)  Individualized Education Plan (IEP)  Behaviour Support Plan  Other: |