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

Supplemental Referral Information

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

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Date URS Referral submitted:** |       |  | **Child/Youth’s OAP #:** |       |  |
|  |  | *(if # not yet received/availablecomplete 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)* |  |

|  |
| --- |
| 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 |



|  |
| --- |
| **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      |

|  |  |
| --- | --- |
| **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:       |

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

|  |  |
| --- | --- |
| **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:       |

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

|  |
| --- |
| **What is the family hoping to achieve through participating in the Urgent Response Service?** |
|       |

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

|  |
| --- |
| **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:       |