CENTRALIZED INTAKE GENERAL REFERRAL FORM

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)
- FIREFLY (All services)
- Kenora Association For Community Living (Children's Serv. only)
- Kenora & Rainy River Districts Child and Family Services (Children's Mental Health + Developmental Services only)
- Kenora Chiefs Advisory (Developmental Services only)
- Northwestern Health Unit
- Sioux Lookout First Nations Health Authority (Develop. Services only)

NON-CRISIS REFERRALS ONLY

If you are the caregiver 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/

MANDATORY SECTION:

Youth/Parent/Guardian Signature: Date:

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:***

Name & role of referring party: Date:

Referrer Agency/School: Phone:

Mailing & Email address: Fax:

Child's Name: *(First and Last)* Date of Birth: *MM DD YYYY*

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:

Health Card: *(# + Version Code)* Ontario Autism Program #: *(Required if referring for OAP programs)*

Preferred Language: ☐ English ☐ French ☐ Indigenous Interpreter Required? *(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

Please submit the fully completed form and required attachments to our Central Intake Toll Free Fax Line at 1-866-470-1783 or by email to intake@fireflynw.ca. Emailed documents MUST BE password protected.

Child or Youth's Name	Date of Birth (MM/DD/YYYY)

Parent/Caregiver: Relationship to Child:

Physical Address:
(if different than youth's)

Mailing Address: ☐ (Check if same as physical)

Home Phone: Cell: Email:

What is the preferred method/ time to contact the family?

If family/client does not have phone, OK to leave non-detailed message at: (phone number) Description:

*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:*

Agency Name: Agreement Type:

Worker's Name: Phone:

Email Address: Fax:

School Information: Does this child have an IEP? ☐ No ☐ Yes

School/Child Care Centre:_____ Grade:_____

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/ and any previous assessments/reports from the child's OSR).

☐ SBRS Occupational Therapy ☐ SBRS Physiotherapy ☐ SBRS Speech Language Pathology

☐ Education and Community Partnership Program (formerly Section 23, FIREFLY, Transitions North, Spark)

Referral Selection: Ontario Autism Programs (OAP) - Must be registered with the Ontario Autism Program

☐ OAP Autism Urgent Response - *Must also complete the OAP URS Supplemental Referral Form, found here https://www.fireflynw.ca/get-help-now/*

☐ OAP Entry to School - *Must have received Ministry invitation to participate*

☐ OAP School Support Program - *Must be referred by the school*

☐ OAP Caregiver-Mediated Early Years Program - *Must have received Ministry invitation to participate*

☐ OAP Fee for Service - ABA Behaviour Consultation

☐ OAP Fee for Service - Core Child & Youth Mental Health Services

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Child or Youth's Name	Date of Birth (MM/DD/YYYY)

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-school entry
- ☐ Child/Youth Development (6 yrs +)
- ☐ Speech Language Pathology (0-6 yrs)
- ☐ Speech Language Pathology (6 yrs+)
- ☐ Occupational Therapy
- ☐ Physiotherapy
- ☐ Respite Services
- ☐ Registered Dietitian
- ☐ Other:
- ☐ NW Autism Diagnostic Hub
- ☐ Fetal Alcohol Spectrum Disorder Assessment
- ☐ FASD Support Worker
- ☐ Service Coordination/Family Navigator
- ☐ Psychology/Psychiatry
- ☐ Picky Eaters Parent Group
- ☐ Children's Mental Health
- ☐ Pediatrician Clinic *valid health card is required
- ☐ Feeding and Swallowing Clinic
- ☐ Seating and Mobility Clinic
- ☐ Augmentative and Alternative Communication Clinic
- ☐ Healthy Babies Healthy Children

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, behavioural assessments and reports etc., including those that identify a previous diagnosis)

If referring for Fetal Alcohol Spectrum Disorder Clinic, is there confirmed alcohol consumption during pregnancy?

☐ Yes ☐ No ☐ Suspected ☐ Unknown

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Child or Youths Name	Date of Birth (MM/DD/YYY)

Other Service Providers, Agencies, Physicians, Community Resources Involved? Please list as many as possible:

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

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 complete? (ie. Wheelchair Accessibility, documents produced in large type or Braille, access to text-to-spech software, specific appointment scheduling to allow or regular medical routines, meetings held in their home etc.) ☐ No

Any other information that is important or helpful regarding this referral?

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