CENTRALIZED INTAKE
GENERAL REFERRAL FORM

DISTRICTS OF KIIWETINOONG, KENORA-RAINY RIVER - 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 or youth requesting Child and Youth Mental Health Services,
to help speed up the Intake Process, please assist the capable child or youth in completing the ***Online 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: _____

Referring Party's Information:

Name of Referring party: _____ Date: _____

Role of Referring party: _____ Phone: _____

Referring Organization/School: _____ Fax: _____

Mailing Address: _____

Email Address: _____

Child/Youth Information:

Legal First Name: _____ Date Of Birth: _____ *(MM/DD/YYYY)*

Legal Last Name: _____

Chosen Name: _____

Gender: _____

Pronouns: ☐ he/him/his ☐ she/her/hers ☐ they/them/theirs ☐ xe/xem/xyrs ☐ ze/zert/zer

☐ ze/zie/hir/hirs ☐ she/they ☐ he/they ☐ Specify: _____

Anishinaabe Name: _____ Clan: _____

Band Name: _____

Health Card : _____ *(# + Version Code + expiry date)*

Ontario Autism Program # : _____ ***(Required if referring for OAP Programs)***

Please submit the fully completed form and required attachments to our Centralized 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)**

Preferred Language: ☐ English ☐ French ☐ Indigenous ☐ Interpreter Required? _____
(if yes, for what language)

Physical Address: _____

Mailing Address: ☐ *(check if same as physical)* _____

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: _____ Description: _____
(Phone Number)

*If the child/youth's caregiver (listed above) is **not** their legal guardian, or the child/youth is in the care of a Child Welfare agency:*

Agency Name: _____ Agreement Type: _____

Worker's Name: _____ Phone: _____

Email Address: _____ Fax: _____

School Information: Does the 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 Selection:**

☐ Please check here if referral is for **School-Based Rehabilitation Services (SBRS)**, please also attach required screening questionnaires found on our **FIREFLY Website** (download at https://www.fireflynw.ca/intake/) and any previous assessments/reports from the child's Ontario Student Record.

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

☐ Education and Community Partnership Program

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

Referral Selections:

*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.*

Primary Care Providers

Referrals for **Psychiatry Services** must be made through **OCEAN** by a Primary Care Provider (where multiple services can be requested at the same time) and the client must have a valid health card number.

Referrals for **Paediatrician** access must be made to **North West Paediatrics Central Intake.**

Clinical Services

- ☐ Child & Youth Mental Health - assist the capable child or youth to complete an Online Self-Referral using the link above to expedite their CYMH Intake
- ☐ Occupational Therapy
- ☐ Physiotherapy
- ☐ Speech Language Pathology (Pre-School)
- ☐ Registered Dietitian
- ☐ Speech Language Pathology (School aged)

Developmental and Family Services

- ☐ Autism (ASD) Support Worker
- ☐ Child and Youth Development (6 yrs +)
- ☐ FASD Support Worker
- ☐ Service Coordinator
- ☐ Healthy Babies Healthy Children
- ☐ Respite Services
- ☐ Infant Child Development (0-school entry)

Ontario Autism Programs (OAP) – Must be registered with the Ontario Autism Program

- ☐ Caregiver Mediated Early Years Program (Must have received Ministry Invitation to participate)
- ☐ Core Clinical Service – ABA Behaviour Consultation
- ☐ Core Clinical Service - Child & Youth Mental Health
- ☐ Entry to School
- ☐ Urgent Response Service (*Must also complete the OAP URS Supplemental Referral Form, found here https://www.fireflynw.ca/intake/*)

Specialty Services

- ☐ Augmentative Alternative Communication Clinics
- ☐ Complex Feeding and Swallowing Clinic
- ☐ Seating and Mobility Clinic

Diagnostics

- ☐ NWO FASD Diagnostic Clinic
- ☐ NW Autism Diagnostic Hub

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

Reason for Referral: Please Provide a brief description of the problem/concern/need.
(To assist in the referral process, if the client consents, please also attach any relevant medical, psychological, behavioural assessment 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 ☐ Unknown ☐ Suspected

Are you seeking: ☐ Support(s) / service(s) OR ☐ diagnosis

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

Does the client/family require any assistance or accommodations in order to participate in a **telephone meeting** with an Intake worker? (i.e. 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 ○ Yes

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? (i.e. Wheelchair Accessibility, documents produced in large type or Braille, access to text-to-speech software, specific appointment scheduling to allow regular medical routines, meetings held in their home etc.) ***If yes, please have the client/family member describe what accommodations would best assist them:***

○ No ○ Yes

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

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