



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 : _____ Ontario Autism Program # : _____
(# + Version Code + expiry date) (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

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) _____
-------------------------------------	---

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
- Core Clinical Services - Occupational Therapy
- Entry to School
- School Support Program
- 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

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) _____
------------------------------	----------------------------------

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?

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.