

**DUFFERIN WELLINGTON  
COORDINATED SERVICE PLANNING / COMPLEX SPECIAL NEEDS  
REFERRAL FORM**

<b>Date of Referral</b> (mmm-dd-yyyy)	
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<b>Child or Youth Information</b>			
First Name		Last Name	
Date of Birth (mmm-dd-yyyy)		Gender	
Street Address		Unit	
City/Town		Postal Code	

<b>Parent/Guardian 1 Information</b>			
First Name		Last Name	
Relationship to Client			
Primary Contact Number		Alternate Number	
Email Address		<input type="checkbox"/> Consent to contact you by Email	
Best Contact Day/Time		Preferred Method of Contact" <input type="checkbox"/> Telephone <input type="checkbox"/> Email <input type="checkbox"/> Text	

<b>Parent/Guardian 2 Information</b>			
First Name		Last Name	
Relationship to Client			
Primary Contact Number		Alternate Number	
Email Address		<input type="checkbox"/> Consent to contact you by Email	
Best Contact Day/Time		Preferred Method of Contact" <input type="checkbox"/> Telephone <input type="checkbox"/> Email <input type="checkbox"/> Text	

Child or Youth lives with:  Both Parents/Guardians (*include both names above*)  
                                   **or**  Parent/Gurdian 1   **or**  Parent/Guardian 2  
                                   **or**  Other, please explain:

Languages spoken in the home:  
 - Interpreter Required:  Yes   or    No                      Preferred Language:

Does the child/youth identify as First Nation, Metis or Inuit?    Yes   or    No  
 If yes, specify which Nation/Band:

<b>School Information</b>			
School Board Name		Grade	
School Name		School Phone	
Main Contact Name		Main Contact phone	
		Main Contact email	

**Pathway for Complex Special Needs (CSN)**

**Fields marked with an asterisk \* are mandatory**

- \* Child has chronic, severe (*depth*), complex conditions (*breadth - multiple areas of impacted development such as: communication, mobility, socialization*) including developmental, neurodevelopmental, mental, and/or physical impairments.
- \* Child is receiving services and supports and continues to experience impaired functioning impeding healthy participation in home, school, and community, which is having a negative impact on the child's health and well-being.

**Stop here for Complex Special Needs pathway ONLY**

**Pathway to Coordinated Service Planning (CSP)**

PLEASE NOTE: The following information MUST be true for the referred child/youth to be eligible for Coordinated Service Planning.

- Child/Youth resides in Dufferin or Wellington Region
- Child/Youth is between the ages of 0 – 18 or 21 years old and younger, still enrolled in school
- Child/Youth is currently accessing two or more services (*with different agencies and/or within same agency*)

What are the goals for CSP? (*i.e.: What are we helping you with?*)

**1) Characteristics of child/youth with multiple and/complex special needs (Check all that apply)**

- Child or youth with multiple and/or complex special needs.
- Child or youth requires multiple specialized services (*e.g.: rehabilitation services, autism services, fetal alcohol spectrum disorder, health services, developmental services and/or respite support*) due to the depth and breadth of their needs.

List which is required:

- List any barriers to required supports and services, due to caregiver capacity, or situational factors (*e.g.: health and well-being of families, severe financial constraints, significant family event, substance use*):

- List Health and Medical Concerns including:
  - Diagnosis or Suspected Diagnosis (*if applicable*): \_\_\_\_\_
  - Date of diagnosis: \_\_\_\_\_
  - Diagnosed by whom: \_\_\_\_\_

- List Child, Youth and Family Strengths:

The child, youth and/or family is currently receiving the following services/supports:

Service/Agency/Doctors	Contact Name	Start Date (mmm-dd-yyyy)

The child, youth and/or family is currently on a waitlist for the following services:

Service/Agency/Doctors	Service Provider	Waitlist Date (mmm-dd-yyyy)

The following services have been explored and/or exhausted:

Service/Agency/Doctors	Contact Name	Start Date (mmm-dd-yyyy)	End Date (mmm-dd-yyyy)

Referral Date: (mmm-dd-yyyy)		<input type="checkbox"/> Referral has been reviewed with family	
Referent Name & Role:			
Referent email:		Referent Phone:	
Referring Agency:			

**Please send completed referral form and consent to Dufferin Child and Family Services:**

**by email: [centralintake@dcafs.on.ca](mailto:centralintake@dcafs.on.ca): or by fax: 519-941-1525**

655 Riddell Road, Orangeville, Ontario, L9W 4Z5  
Phone 519-941-1530