|  |  |
| --- | --- |
| Date of Referral: Click or tap to enter a date. *(mm-dd-yyyy)* | Name of Referent: |
| Your professional relationship to the child/youth: | |
| Your Agency/Service Affiliation: | |
| Your Agency/Service Address: | |
| Your Agency/Service Business Phone #: | Cell #: |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Child/Youth’s Full Name: | | |  | | Gender:  M  F  Trans  Other |
| Date of Birth: | | Click or tap to enter a date. | | *(mm-dd-yyyy)* | Age: |
| School: |  | | | | Grade: |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | | *Please X your preferred phone number* | | | |
| Home Address: |  |  | Phone Home: |  |  |
| Town |  |  | Phone Work: |  |  |
| Postal Code |  |  | Phone Mobile: |  |  |
| Email: |  |  | Phone Other: |  |  |
|  | | *Please X if it is okay to leave a message* | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| Family Members *(first and last name)* | Relationship to Client | | Date of Birth *(mm-dd-yyyy)* |
|  |  | |  |
|  |  | |  |
|  |  | |  |
|  |  | |  |
|  |  | |  |
|  | | | |
| Client’s Legal Guardian: | | Lives with: | |
| Are you currently involved in any legal process regarding custody and access? Yes  No | | | |
| Is there a legal custody agreement? Yes  No  N/A | | | |
| If Yes: Custody Type:  Sole Custody Mother  Sole Custody Father  Joint Custody  Interim  Guardian  Other  If Other, please explain: | | | |

**Please include a Client Consent to Share Information Form**

|  |  |
| --- | --- |
| 1. | Has the child or family received services from our agency in the past? |
|  | No  Yes  If yes, approximate date: |
|  | If yes, which service(s) *check all that apply*:  Crisis  Child & Youth Mental Health  Child Protection  Infant & Child Development  iCAN  Service Coordination  Coordinated Service Planning  FASD  OAP  Groups (please list):        Other: |
|  | If yes, please provide relevant details: |

|  |  |
| --- | --- |
| 2. | What concerns do you have about this child/youth/family? |
|  |  |
|  |  |

|  |  |
| --- | --- |
| 3. | How would you rate your concerns for this child/youth/family? Scale of Worries (0=Highest, 10=Lowest) |
|  | Highest 0 1  2  3  4  5  6  7  8  9  10  Lowest |

|  |  |
| --- | --- |
| 4. | What is the one worry, challenge or concern that seems important to work on now? |
|  |  |
|  |  |

|  |  |
| --- | --- |
| 5. | What would be important for us to know about the background of this worry, challenge or concern? |
|  |  |
|  |  |

|  |  |
| --- | --- |
| 6. | What would you like to see accomplished in our initial meeting? |
|  |  |
|  |  |

|  |  |
| --- | --- |
| 7. | In what ways to you currently provide support to this child/youth/family? |
|  |  |
|  |  |
|  |  |

|  |  |
| --- | --- |
| 8. | In what ways could you offer further or different support? |
|  |  |
|  |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **CLIENT STRENGTHS**: *choose all that apply with categorization levels 1 and 2 (level 3’s should go in the needs section):*  *1=Key strength 2=Opportunity for Strength Development 3=No Strength-Needs Development* | | | | | | | | | | | | | | | | | | | | |
| **ATTRIBUTES** | | | | | | | | | | | | | | | | | | | | |
| Consistent Positive Outlook | | | | Good decision-making skills | | | | | | | | Cognitive flexibility – adapts to change | | | | | | Social Skills – has social perception | | |
| Physical Health | | | | Ability to pay attention | | | | | | | | Cognitive flexibility – transitions | | | | | |  | | |
| Resiliency | | | | Emotional Reg – Self Mgmt | | | | | | | | Social skills – builds relationships | | | | | |  | | |
| Resourcefulness | | | | Emotional Reg – Anger Control | | | | | | | | Social skills - Shows empathy | | | | | |  | | |
| **TALENTS** | | | | | | | | | | | | | | | | | | | | |
| Creative / Artistic | | | | | | | Athletic / Sports, Dance, etc | | | | | | Technical or Mechanical skills/abilities | | | | | | Scientific | |
| **ACTIVITIES** | | | | | | | | | | | | | | | | | | | | |
| Good school performance in last 6 months | | | | | | | | | Actively engaged in school activities | | | | | | | Involvement in structure activities | | | | |
| **FORMAL/INFORMAL SUPPORTS** | | | | | | | | | | | | | | | | | | | | |
| Has a Confidant | | | | | | | | | Strong supportive relationship with Peers | | | | | | | Socializes with at least one friend regularly | | | | |
| **FAMILY RELATIONSHIPS** | | | | | | | | | | | | | **FAMILY ATTRIBUTES** | | | | | | | |
| Relationship permanence / Stability | | | | | | | | | | | | | Strong supportive relationship with family | | | | | | | |
| **CULTURAL IDENTITY** | | | | | | | | | | | | | **OTHER STRENGTHS** | | | | | | | |
| Strong sense of community involvement | | | | | | | | Spiritual / Religious | | | | | Other (list): | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| **CLIENT NEEDS**: *choose all that apply with categorization levels of 2 or greater:*  *1=No Need (no rank required) 2=Risk/No Action 3=Need Identified/Action 4=Urgent/Priority Need* | | | | | | | | | | | | | | | | | | | | |
| **BEHAVIOURAL** | | | | | | | | | | | | | | | | | | | | |
| ADHD/ADD (diag susp) | | | Aggression | | | | | | | | ASD (diag susp) | | | | Behaviour Issues | | | | | |
| Bullying - Aggressor | | | Conduct Disorder (diag susp) | | | | | | | | Fire play/involvement | | | | Oppositional Defiance Disorder (diag susp) | | | | | |
| Problematic Absenteeism | | | YOA Involvement | | | | | | | | Stealing/Destruction of property | | | | | | | | | |
| **EMOTIONAL** | | | | | | | | | | | | | | | | | | | | |
| Anger issues | | | | | Anxiety (generalized) | | | | | | Anxiety (separation) | | | | | | Attachment issues | | | |
| Bi-Polar (diag susp) | | | | | Body image issues | | | | | | Depression (diag susp) | | | | | | Eating issues | | | |
| Encopresis (soiling) | | | | | Enuresis (wetting) | | | | | | Grief | | | | | | Low-Self-esteem | | | |
| OCD (diag susp) | | | | | Phobias | | | | | | Selective mutism | | | | | | Sleeping Issues | | | |
| Sensory issues | | | | | Sep/Div. Impact | | | | | | Thinking distortion | | | | | |  | | | |
| **SOCIAL** | | | | | | | | | | | | | | | | | **Self-Harm** | | | |
| Bullied (victim) | | | | | Isolation/withdrawal | | | | | | Parent Challenges/Support needed | | | | | | Self-Harming behaviours | | | |
| Bulling (aggressor) | | | | | Lack of Social participation | | | | | | Family Relationship issues | | | | | | Suicidal Ideation | | | |
| Peer Relationships issues | | | | | School Performance issues | | | | | | Separation/Divorce Impact | | | | | | Suicidal Attempt | | | |
| **ADDICTIONS & SUBSTANCE MISUSE** | | | | | | | | | | | | | | | | | | | | |
| Addictions - GAMING | | | | | Alcohol/Drug misuse (child) | | | | | | Alcohol/Drug misuse (parent) | | | | | | Eating Addictions/Disorders | | | |
| **TRAUMA** | | | | | | | | | | | | | | | | | | | | |
| Abuse (physical/verbal) | | | | | Neglect | | | | | | Bullying - Victim | | | | | | FAS / FASD / FAE (diag susp) | | | |
| Witnessed Abuse/Violence | | | | | Grief | | | | | | PTSD (diag susp) | | | | | |  | | | |
| **SEXUAL** | | | | | | | | | | | | | | **GENDER** | | | | | | |
| Sexual Assault (victim) | | Sexual Assault (perpetrator) | | | | | | | | Sexualized Behaviours | | | | Sexual Orientation | | | | | | Gender Identity |
| **OTHER** | | | | | | | | | | | | | | | | | | | | |
| Developmental Delay | | | | | | Learning disability (diag susp) | | | | | | | Sensory issues | | | | Speech & Language issues | | | |
| Tourette’s (diag susp) | | | | | | Trichotillomania (hair-pulling) | | | | | | | Psychiatric needs | | | | Adaptive-Functioning needs | | | |
| **COMPLEXITY NEEDS LEVEL *(choose one)*** | | | | | | | | | | | | | | | | | | | | |
| Level 1 | All children, youth and their families (no risk) | | | | | | | | | | | | | | | | | | | |
| Level 2 | Children and youth identified as **being at risk** for, or who are experiencing, mental health problems that **affect their functioning** **in** **some areas**, such as at home, school, and/or in the community | | | | | | | | | | | | | | | | | | | |
| Level 3 | Children and youth who are experiencing **significant mental health problems** that **affect their functioning in some areas**, such as at home, school, and/or in the community | | | | | | | | | | | | | | | | | | | |
| Level 4 | Children and youth who are experiencing the **most severe, complex, rare, or chronic/persistent diagnosable mental health problems** that **significantly impair functioning** in most areas such as home, school and in the community. | | | | | | | | | | | | | | | | | | | |

**Consent to Disclose/Exchange Information**

This consent is for the purpose of sharing information, to assist with planning and providing quality service

|  |  |  |
| --- | --- | --- |
| **Name(s):** |  |  |
| (client/parent/guardian) (relationship to client) | |

|  |  |  |  |
| --- | --- | --- | --- |
| **The information to be shared is about:** | myself | and/or | my child(ren) |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Full Name of Child Date of Birth (*mm/dd/yyyy*) | |  | Full Name of Child Date of Birth (*mm/dd/yyyy*) | |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

|  |  |  |
| --- | --- | --- |
| **I/We Authorize** *(Agency/Service/Dept/Practitioner)***:** | |  |
| To release information to: |  | |
| To exchange information with: |  | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Type of Disclosure:** | | | |
| Verbal Information | Copies of Records *and/or* Assessment(s) | | Written Information |
| Specific Information to be released: | |  | |
| Purpose of release/exchange of information: | |  | |
|  | |  | |

*I understand that the information to be shared is confidential and that it will not be shared with any other person or service unless Dufferin Child & Family Services is required by a court to share it, or if there is a risk of harm to self or others.*

*I understand that consent to share information is voluntary and that I can withdraw my consent upon verbal or written notice to Dufferin Child &Family Services at any time.*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Unless otherwise revoked, this consent expires on**  *(date/or file closing (mm/dd/yyyy)***:** | |  | | | |
| Verbal Consent *(name of consenting client/parent/guardian):* |  | | | Date: |  |
|  | | | *mm/dd/yyyy* | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Signature: |  | Date: |  | *Witness:* |  |
|  | *(client/parent/guardian)* |  | *mm/dd/yyyy* |  |  |
| Signature: |  | Date: |  | *Witness:* |  |
|  | *(client/parent/guardian)* |  | *mm/dd/yyyy* |  |  |
| Signature: |  | Date: |  | *Witness:* |  |
|  | *(client/parent/guardian)* |  | *mm/dd/yyyy* |  |  |