|  |  |
| --- | --- |
| 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 [ ]  OtherIf 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:       |

|  |  |
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| 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? |
|  |       |
|  |       |

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

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

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| **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*) |
|       |       |  |       |       |
|       |       |  |       |       |
|       |       |  |       |       |
|       |       |  |       |       |

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| **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* |  |  |