CENTRALIZED INTAKE GENERAL REFERRAL FORM

KENORA & RAINY RIVER DISTRICTS – 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 (Dev. Serv. Only)

NON-CRISIS REFERRALS ONLY

If you are the caregiver of a child/youth requesting Children's Mental Health services, please consider assisting the child/youth to complete the **Online Self-Referral** form to speed up their Intake process; https://fireflynw.ontarionow.ca/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:*** __________

Name & role of referring party: ____________________ Date: __________

Referring Agency/School: ____________________ Phone: __________

Mailing & Email address: ____________________ Fax: __________

Child's Name: ____________________ *(First and Last)* Date of Birth: __________ *(MM/DD/YYYY)*

Anishinaabe Name: ____________________ Clan: __________

Band Name: ____________________

Gender: ____________________

Pronouns: ☐ he/him/his ☐ she/her/hers ☐ they/them/theirs ☐ xe/xem/xyrs ☐ ze/zer/zers ☐ ze/zie/hir/hirs ☐ she/they ☐ he/they ☐ Specify: __________

Health Card: ____________________ *(# + Version Code)* Ontario Autism Program #: __________ ***(Required if referring for OAP programs)***

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

Physical Address: ____________________

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

NOTE: A complete mailing address (PO Box, City & Postal Code) is extremely important for sending correspondence regarding this referral.

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

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: ____________ ***(phone number)*** Description: ____________

*If the child's caregiver (listed above) is **not** his/her legal guardian, or the child 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 this client is being referred from **School Board Counselling to Agency-Provided Children's Mental Health Counselling.***

☐ *Please check here if referral is for **School-Based Rehabilitation Services***
If yes, please also attach required screening questionnaires (download at https://www.fireflynw.ca/get-help-now/ and any previous assessments/reports from the child's OSR).

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

☐ Education and Community Partnership Program (formerly Section 23, FIREFLY, Transitions North, Spark)

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Child or Youth's Name ______________________ **Date of Birth (MM/DD/YYYY)** ____________

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

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

Referral Selections: Identify which program(s) the child is being referred to:

*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.*

- ☐ Infant/Child Development (0-school entry)
- ☐ Child/Youth Development (6 yrs.)
- ☐ Speech Language Pathology (0yrs)
- ☐ Speech Language Pathology (6 y+)
- ☐ Occupational Therapy
- ☐ Physiotherapy
- ☐ Respite Services
- ☐ Registered Dietitian
- ☐ NW Autism Diagnostic Hub
- ☐ Fetal Alcohol Spectrum Disorder Assessment
- ☐ FASD Support Worker
- ☐ Service Coordination/Family Navigator
- ☐ Psychology
- ☐ Psychiatry
- ☐ Children's Mental Health
- ☐ Pediatrician Clinic *valid health card is required
- ☐ Complex Feeding and Swallowing Clinic
- ☐ Seating and Mobility Clinic
- ☐ Augmentative Alternative Communication Clinic
- ☐ Healthy Babies Healthy Healthy Children

☐ Other: ____

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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
(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 Suspected Unknown

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

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

No Yes

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

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