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 (Develop. Services only)

NON-CRISIS REFERRALS ONLY

If you are the caregiver of a child/youth requesting Children's Mental Health services, to speed up their Intake Process please consider assisting the child/youth to complete 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:*** _____

Name & role of referring party: _____ Date: _____

Referring _____ Phone: _____

Mailing & Email address: _____ Fax: _____

Child & Youth Name: _____ Date Of Birth: _____
(First and Last) ***(MM/DD/YYYY)***

Anishinaabe Name: _____ Clan: _____

Band 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: _____

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

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.

NON-CRISIS REFERRALS ONLY

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, _____ Description: _____
OK to leave non-detailed message at: ***(phone number)***

*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 http://dev.fireflynw.ca/intake/ 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 http://dev.fireflynw.ca/intake/
- ☐ 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 (Pre-School)
- ☐ Speech Language Pathology (School aged)
- ☐ Occupational Therapy
- ☐ Physiotherapy
- ☐ *Psychiatry
- ☐ NW Autism Diagnostic Hub
- ☐ Fetal Alcohol Spectrum Disorder Assessment
- ☐ FASD Support Worker
- ☐ Service Coordination/Family Navigator
- ☐ Psychology
- ☐ Respite Services
- ☐ *Pediatric Clinic
- ☐ Children's Mental Health
- ☐ Registered Dietitian
- ☐ Complex Feeding and Swallowing Clinic
- ☐ Seating and Mobility Clinic
- ☐ Augmentative Alternative Communication Clinic
- ☐ Healthy Babies Healthy Children
- ☐ Other: _____

*Referrals for **Psychiatry Services** and the **Pediatric Clinic** must come from a Primary Care Provider, must be made through OCEAN (where multiple services can be requested at the same time) and the client must have a valid health card number.

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NON-CRISIS REFERRALS ONLY

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 ☐ 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:

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.)

○ No ○ Yes

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

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