North Eastern Ontario
Family and Children's Services
Services à la famille et à l'enfance
du Nord-Est de l'Ontario

Referral Form
Mental Health Programs

Program	
☐ Autism Resources Program (ARP)	☐ Counselling and Therapy (CTS) Brief Services
☐ Family Preservation Program (FPP)	☐ File Disclosure

Campus				
☐Cochrane	☐Kapuskasing	☐Hearst		
☐Iroquois Falls	☐Timmins	☐Smooth Rock Falls		
☐Kirkland Lake	☐New Liskeard	☐Englehart		
Date of Referral:	/ / DD MM YY		Time:	am pm

Referral Source	
Name:	
Relationship:	
Name of Organization: *(if applicable)*	
Address: *(including P.O. Box number)*	
Phone Number:	
Method of Referral :	☐Phone call ☐Letter/Fax ☐Face to face

Client Information			
Child/Youth's Name:	Alias/Known As:		CIMS File Number:
Date of Birth :	Gender:		
/ / DD MM YY			
Address/City/Prov/Postal Code/Box #:	Telephone Numbers :		Worker can call #:
	Home:		☐Yes ☐No
	Cell:		☐Yes ☐No
	Other:		☐Yes ☐No
School/ Grade:	Ethnic Origin/First Nation:		
Language:	☐English ☐French ☐Other:		
Living With:			

Family Information			
Mother/Guardian:		Maiden Name:	
Address/City/Prov/Postal Code/Box #:		Telephone Numbers:	
		Home:	
		Cell:	
		Other:	
Partner name (If Applicable):		Marital Status:	
Language:	☐English ☐French ☐Other:		
Legal Guardian: ☐Yes ☐No	Primary Contact: ☐Yes ☐No	Send Correspondence: ☐Yes ☐No	
Father/Guardian:			
Address/City/Prov/Postal Code/Box #:		Telephone Numbers:	
		Home:	
		Cell:	
		Other:	
Partner name (If Applicable):		Marital Status:	
Language:	☐English ☐French ☐Other:		
Legal Guardian: ☐Yes ☐No	Primary Contact: ☐Yes ☐No	Send Correspondence: ☐Yes ☐No	

	Child # 1	**Child # 2**	**Child # 3**	**Child # 4**
Sibling Name				
Birth Date (mm/dd/yy)				
Alias/Known As				
Living With				
Relationship to client				
Gender				
Address				
City				
Province				
Postal Code				
Home Phone				
Cellular Phone				

PRESENTING PROBLEMS/CLIENT NEEDS: *(Identify presenting problems according to client or parents/caregivers and where these occur i.e. home, community, how long have the difficulties been present, etc.)*

CONSULTATION AND THERAPY SERVICES CTS - AREAS OF CONCERNS:
PLEASE ONLY CHOOSE MAX OF 3

- ☐ Adoption Issues
- ☐ Agressive Behavior
- ☐ Alcohol Issues- Self/Family
- ☐ Anger Management
- ☐ Anxiety Issues
- ☐ Attachement Issues
- ☐ Attention/Concentration/Hyperactivity
- ☐ Autism
- ☐ Bullying
- ☐ Child Management Issues
- ☐ Depressive Issues
- ☐ Developmental Delay
- ☐ Drug Issues- Self/Family
- ☐ Eating Behavior/Issues
- ☐ Emotional Regulation
- ☐ Encopresis/Enuresis
- ☐ Family Conflict
- ☐ Fire Setting
- ☐ Gender Identity Issues
- ☐ Hallucinations
- ☐ Health Concerns
- ☐ Homicidal Ideation
- ☐ Loss & Grief
- ☐ Parent/Teen Conflict
- ☐ Parental Mental Health Issues
- ☐ Pregnancy Issues
- ☐ School Based Issues
- ☐ Self Esteem Issues
- ☐ Self-Injury/Self-Harming Behavior
- ☐ Separation/Divorce/Blended Family Issues
- ☐ Sexual Identity
- ☐ Sexually Inappropriate
- ☐ Social Issues
- ☐ Suicide Threat/Attempt/ Ideation/Gesture
- ☐ Trauma
- ☐ Other Specify :

FAMILY PRESERVATION PROGRAM FPP - AREAS OF CONCERNS :
PLEASE ONLY CHOOSE MAX OF 3

- ☐ Adoption Issues
- ☐ Aggressive Behavior
- ☐ Anxiety
- ☐ Attachment Issues
- ☐ Attention/Concentration/Hyperactivity
- ☐ Child Management Issues
- ☐ Child Neglect
- ☐ Child of Developmental Disability Parent
- ☐ Disruptive Behavior
- ☐ Emotional Regulation
- ☐ Family Conflict
- ☐ Family Violence
- ☐ Innapropriate Sexual Behavior
- ☐ Loss & Grief
- ☐ Oppositional Defiance
- ☐ Parent Mental Health Issues
- ☐ Parenting Issues
- ☐ Prematurity/Newborn High-Risk Follow Up
- ☐ Separation/Divorce/Blended Family Issues
- ☐ Trauma

AUTISM RESOURCES PROGRAM ARP - AREAS OF CONCERNS:
PLEASE ONLY CHOOSE MAX OF 3

- ☐ Aggressive Behavior
- ☐ Autism Spectrum Disorder
- ☐ Coordination of Services
- ☐ Disruptive Behavior
- ☐ Emotional Regulation
- ☐ Life Skills
- ☐ Other Emotional/ Behavioral
- ☐ Preparation for Independence
- ☐ Social Skills
- ☐ Starting School

Autism Resource Program Referral — Diagnosis Report: ☐ Attached ☐ Available in CIMS

Other Service Providers Involved

Agency	Worker's Name	Current	Previous
		☐	☐
		☐	☐
		☐	☐

PHIPA – Personal Health Information Protection Act	
PHIPA script explained to client	☐Yes ☐No
PHIPA Script: •The agency is part of a Circle of care that collects personal health information in order to inform you of available services as well as assisting us to refer you to the most appropriate service providers. •I am advising you today that our referrals are kept in a web-based electronic file. Our Agency is committed to maintaining the confidentiality and security of the electronic file and has a number of measures in place to protect the privacy of your information.	
Is client in agreement that the referral and information being collected today is inserted in a web-based electronic file?	☐Agrees ☐Declines

BCFPI - Brief Client & Family Phone Interview	
BCFPI script explained to client	☐Yes ☐No
BCFPI Script: •The BCFPI is a 30-45 minute multiple choice questionnaire completed by phone for children 6 and older for all mental health services. The BCFPI helps to identify the areas of concern as well as provides program recommendations for the Clinician for a more effective intervention. •Children 12 and older must consent to mental health services and are offered their own BCFPI that takes approximately 15-20 minutes to complete. •Parents of children 12 and older may also complete one if the youth does not want to complete it or if it is a referral to the Family Preservation Program. •The BCFPI can be completed through the school (where available), at home or at work with a parent or youth between the hours of 8:30 am-4:30pm.	
Is the parent (for child 6+) in agreement to complete the BCFPI?	☐Agrees ☐Declines
Is the youth (12 +) in agreement to complete the BCFPI?	☐Agrees ☐Declines

A Consent for Disclosure signed by parent (s)/guardian (s) and child (if child is 12 years and older) must be included with the present referral form if referral is completed by a non-mental health program.

Parents' Contact Allowed (if child is 12 years and older) ☐Yes ☐No

SIGNATURES

Worker Completing Form	Supervisor Signature
Date: (mm/dd/yy)	Date: (mm/dd/yy)