ᒐᓪᑲᑲᑭᓄᑦ ᐁᐊᓇᑭᑕᕐᑦ ᐃᓐ ᑲᑭᐅᑦᐸᑭᑎᑲᑲᒍ
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LAST NAME	(FIRST)
MRN	VISIT NUMBER
DATE OF BIRTH YYYY-MM-DD	SEX
ADDRESS	

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ᑲᐃᓇᑭᑕᓗᒃ ᑲ· ᐃᒋᐃᑦ Agency client # _____ MRN _____

ᐊᐱᐸᑭᑎᑲᑲᒍ ᑲ· ᕐ· ᑐ ᐃᓐ Date of request _____
YYYY - MM - DD

· ᐃᒋᐃ ᐁ ᐃᓐ ᑲᑕᓇᑲᑲᒍ Coordinating agency: ☐ AFS ☐ ᑎᓗᑯ Dilico ☐ HANDS ☐ SOAHAC
☐ · ᐃᒋᐃᑎ ᐃᓐ Weechi-it-te-win ☐ ᐅᑉᐱᕐ Woodview

ᑲᑭᑲ· ᕐ· ᑐᑕᕐᑦ Referring agency _____

ᐊᓗᑎ Location _____ ᑭᑭᑐ ᐃᓐ # Telephone _____

ᑭᑭᑐ ᐃᓐ ᒪᒋᐊᓯᒋᑲᓐ ᐸᑭᑕᓐ ᑎᐊᒋᒧ· ᐃᓐ ᕐᐃᐃᓕᐃᑲᑲᒍ (1# ᐯᐃᕐ ᐊᓇᑭ· ᐃᑲᒥᒃ ᑲᔪ ᐊᓗᑎ) Fax # _____

ᒪᔭ ᑲᐅᒋᐊᓇᑭᑕᕐᑦ Case manager _____

ᐊᓂᓐ ᐁᐱᒋᒃᑲᒪᑲᓂᒃ ᐅᑎᓇᐱᓐᓐᑦ ᒋᑉᐸ ᑉᐃᑐᑲᑉᐃᑦ Severity scale prior to service ☐ 1 ☐ 2 ☐ 3 ☐ 4

☐ ᓂᑕ· ᐊᐊᒥᑯ· ᐃᓐ First consultation ☐ ᓇᓴᐱ ᐊᐊᒥᑯ· ᐃᓐ Follow-up
☐ ᑭᒋᐊᓇᑭᑲᓇᒃ ᑲᑭᓇᑭᒃᑲᑎ ᐊᓗ Professional-to-professional consultation
☐ ᑭ· ᐁᓇᑲᒋᐃᑯ· ᐃᓐ (ᑭᒃᐱᓐ ᐊᐱᓂᑕ · ᐊᐊᒥᑯ· ᐃᓐ ᐯᓯᑯᐱᐅᓐ ᐁᑭᑲᒃᑭᐅᓴᒃ ᕐᒪ ᐊ ᐊᒥᒥᒋ· ᐸᑲ· ᕐ· ᑐ ᐃᓐ ᐸᑭᑎᑲᑲᒍ) Re-assessment

ᑲᐃᓇᑭᓯᒃ ᑲ· ᐃᓐ ᐊᓗᓯ· ᐊᓗ Dates not available _____

_____

ᐯᓯᑯᒍ· ᐃᓐ ᐅᒪᒃᑭᑭ· ᐃᓇᒪᓐ ᕐᒪ ᐊᐱᓇᒃ ᒪᒃᑭᑭ· ᐃᓂ Family doctor or paediatrician _____

ᐅᓇᒥᑲᓇ Address _____

ᐅᓇ City _____ ᐳᑐᑯᑦ Postal code _____

ᑭᑭᑐ ᐃᐸᑭᑕᓐ Phone _____ ᑭᑭᑐ ᐃᒪᒋᐊᓯᒋᑲᓐ Fax _____

· ᐃᑦᑕᕐᑦ ᐃᓐ ᐁᑉᑕ ᐁᑕ ᑲᒃ ᒋᑭᒪᑕᑲᑲᒍ · ᐃᒋᐃᑯ· ᐃᓐ Information that is mandatory for referral to proceed

☐ ᐸᑎᑲᓂᑎᓯ· ᐃᓐ ᒧᒃᑭᓗᐱᑲᓐ Consent form ☐ ᓇᓇᑕ ᐃᑭᕐᓂᒥᑯ· ᐃᓐ ᑲᑭᒪ· ᐊᑐᐱᑲᒪᑭᓐ Case summary / assessment

ᐅᑎᐊᒥᑯ· ᐃᓇᓐ ᒋᐅᒋ ᓇᓇᑲᑕ ᐊᐊᒥᑲᒪᑲᒃ ᑭᒃᐱᓐ ᐊᑭᒃᑲᐊ ᐁ ᐃᓇᓇᑲᒋᐃᑯ· ᐃᓐ Information provided for consultation (if available)

☐ ᑲᑭᓱ ᐊ ᐃᑐᑲ· ᐃᓐ Admission Hx ☐ ᑕᑯᓂ ᐁ ᐃᓂᓂᑲᒃ ᐅᑎᐊᒥᑯ· ᐃᓐ Police synopsis ☐ ᑲᑭ ᑭᓱᑐ ᐅ ᐃᑐᑲᑯ· ᐃᓐ ᑎᐊᒋᒧ· ᐃᓐ D/C summary
☐ ᐅᓴᑲᐃᕐ· ᐃᓐ ᐅᓇᑲᒋᐃᑯ· ᐃᓐ ᑭᒃᐱᓐ ᐊᑭᓐ Fire setting assessment ☐ BCFPI ᑭᒃᐱᓐ ᐊᑭᓐ
☐ CAFAS ᑭᒃᐱᓐ ᐊᑭᓐ ☐ ᐁᓇᓇᓴᓂᑭᐅ ᐊᑉᑕ ᐁᑕ ᑲᓐ ᒋᓇᑲᒋᐃᑦ ᑭᒃᐱᓐ ᐊᑭᓐ Risk / Needs assessment

ᑎᐊᒋᒧ· ᐃᓇᓐ Reports: ☐ ᐅᑭᑭᓗᑯ· ᐃᓇᑲᒋᐃᑯ· ᐃᓐ Education ☐ ᒪᒃᑭᑭᕐ· ᐃᓐ ᑲᔪᒥᓂ ᕐ· ᐃᓐ ᓇᓇᒋᐃᑯ· ᐃᓐ Drug & Alcohol
☐ ᓇᓇᑕ ᐁᑕᒧ· ᐃᓂᒃ ᓇᓇᑲᒋᐃᑯ· ᐃᓐ Psychological ☐ ᓂᑕ ᐁ ᐃᓐ ᓇᓇᑲᒋᐃᑯ· ᐃᓐ Speech & Language ☐ ᓴᑲᐊ ᐁ ᐃᓇᓇᑲᒋᐃᑯ· ᐃᓐ Fire setting
☐ ᑭᑭᓗᑎᑲᒥᒃ School ☐ ᑲᐃᓇᐱᓂᒃ ᐅᑎᐊᒥᑯ· ᐃᓐ Relevant medical information ☐ ᐅᑕᒃ ᑲᑭᐱᕐᐱᒪᑎᓯᒃ Social history
☐ ᐅᑕᒃ ᓇᓇᑕ ᐁᑕᒧ· ᐊᐱᓇᓇᑲᒋᐃᑯ· ᐃᓐ ᑲᓴ ᑯᑕᑭᔭᓐ Prior consults ☐ ᑲᑭᕐᐅᓇᒃᑭᒃ ᒋᕐ ᐃᑐᑲ· ᐃᓐ ᕐᒪ ᐅᑎᐊᒥᑯ· ᐃᓐ Service plan / case notes
☐ ᐅᒃᑲᑎᓯ· ᐃᑎᐊᑯᓂᕐᑦ ᐃᓂᒃ ᑎᐊᒋᒧ· ᐃᓐ ᒪᔭ · ᐃᑦᑕ Youth Justice Court documents
☐ ᑯᑕᑭᔭᓐ ᑲᐃᓇᑎᓯᒃ ᑲᐅᕐᐱᐃᑲᒪᑭᓐ: ᓂᐱᒐᐊᐊᒃ Behavioural checklists

ᒐᓴᑲᑲᑭᓄᑦ ᐁᐊᓄᑕᒪᕐᓱ ᐃᓐ ᑲᑭᐅᒋᐸᑭᑎᑲᑲᒐᒃ
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ᐅᑕᓯᒃ ᐅᑎᐊᒥᑯ· ᐃᓐ CLIENT INFORMATION

ᐅᑕᓯᒃ ᐅ ᐃᓯ· ᐃᓐ Patient's name _____ ☐ ᓇᐯ Male ☐ ᐃᓐ ᕿ Female

ᑎᐱᒃᑲᒧ· ᐃᓐ DOB _____
YYYY - MM - DD

ᐅᒐᓕᑲᓇ Address _____

ᐅᒐᓇ City _____ ᐳᑐᑯᑦ Postal Code _____

ᐅᑕᓯᒃᐅᑭᑕᓱᓐ Health Card # _____ ᑎ ᐊᑲ Version _____ ᕿᐃᒃ· ᑲᐸᑕᑦ Exp. _____
YYYY - MM - DD

ᑲᑲᓇ: ᐁᓕᑯᒃ ᐅ ᐃᓯ· ᐃᓂ ᐊ Guardian name(s) _____

ᑲᑲᓇ: ᐁᓕᑯᒃ ᕿᒍᑲᓄᒃ Guardian contact # L ᑐ Primary _____ ᑯᑕᑦ Secondary _____

ᐯᒋ ᑲᓐ ᓇᐃᒋᐱᑲᒐᑲᑲᓇ: ᐁᓕᑯᒃ ᑲᐃᒋᑕᓂᒃ · ᐊᐊᐅᑕᓯᒃ? Is legal guardians' address the same as clients? ☐ ᐁᐁ Yes ☐ ᑲ· ᐃᓐ No

ᑭᒃᐱᓐ ᑲ· ᐃᓐ ᐅᒋᐱᐊᓐ ᐁᒋᑦ ᐁᒋᐱᑲᒐᓂᒃ If no please complete address section

ᐅᒐᓕᑲᓇ Address _____

ᐅᒐᓇ City _____ ᐳᑐᑯᑦ Postal Code _____

ᑎᐸᑯᓂ ᐁᑲᓇ: ᐁᑕᓯᒃ· ᐃᓂᒃ Custodial Status

☐ ᒥᓯ· ᐁᓯ Intact

☐ ᒪᒃᒣ· ᑲᑎᑲᓇ: ᐁᓂᒪ* Joint*

☐ ᐯᒋᑯᑲᓇ: ᐁᓂᒪ* Sole custody*

☐ ᐊᑲ· ᐁᑲᓇ: ᐁᓕᒥ· ᐁ ᐃᓇᑯᒥᑎ ᐃᓐ Temporary Care Agreement

☐ ᐊᑲ· ᐁᑎᐸᑯᓂ ᐁ ᐃᓂᒃ ᕿᐃᒋᑲᓇ: ᐁᓕᒃ Temporary Care and Custody

☐ ᐅᓇᒐᓇᓇᑲᑎᐃᑯ· ᐃᓐ Supervision Order

☐ ᐅᑭᒪ· ᐃᓂᒃ ᐱᓐᑎᕿᕐ Society Wardship Order

☐ ᐊᐱᓂᒋᑭᒪ ᐅᑎᑲᓇ: ᐁᓂᒪ Crown Wardship Order

☐ ᐊᐱᓂᒋᑲᓇ: ᐁᑕᓯᒃ· ᐃᐅᓇᒐ(ᐊᕿᐱᑲᓐ 65.2) Child protection order for custody (s. 65.2)

☐ ᐊᑲᒋᓇᐯᐅᑭᐱᐊ ᐊᒃ ᓇᑯᒥᑎ ᐃᓐ Customary Care Agreement

☐ ᑲᐃᓇ: ᐁᒪᒃ ᑎᑲᓇ: ᐁᓂᒪᒃ ᓇᑯᒥᑎ ᐃᓐ Kinship Agreement

* · ᐊᐸᑕᐃ ᐁᓐ ᑭᑦᑯᓂᕿ· ᐃᒪᓯᓇᐃᑲᓇᓐ *Please provide legal documentation

ᒐᓴᑲᑭᓗᒃ ᐁᐊᓚᑦᑕᕐ· ᐃᓐ ᑲᑭᐅᑦᑭᑎᓄᑲᒍ
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ᐅᑕᓯ ᐅᑎᐊᒥᑯ· ᐃᓐ CLIENT INFORMATION

· ᐁᓐᓐ ᑲ· ᐃᒋᑕᒻ Residence Information

ᑲ· ᐃᒋᑕᒻ Resides with

☐ ᐅᒪᒪᓐ Bio-mother ☐ ᐅᒐᒃ Bio-father ☐ ᐅᑐᓯᓴᓐ Step-mother ☐ ᐅᑯᒥᓴᓐ Step-father

☐ · ᐃᒋᐃ ᕐ· ᐊᑉ ᕐᒪ · ᐃᒋᐃᓂᓂ ᐊᑉ ᑲᐅᓂᑭᐃᑯᒃ Same sex parents ☐ ᐅᑎᓇ: ᐁᒪᑲᓇᓐ Extended family

☐ ᑲᓂᒋᐅᑕᐱᓂᑯᒃ ᐅᒪᒪᓐ Adoptive mother ☐ ᑲᓂᒋᐅᑕᐱᓂᑯᒃ ᐅᒐᒃ Adoptive father ☐ ᐯᓂᑯᑕ Independent living

☐ ᑯᑕᕐ (ᒪᔭ · ᐃᓐᑕᕐ) Other (please explain) _____

ᓂᐱᒐᐱᐅ ᐅ ᐃᓱ· ᐃᓂ ᐊ· ᐁᓐᓐ ᑲ· ᐃᒋᑕᑯᒃ · ᐊᐊᐅᑕᓯ ᑲᓴ ᐊᑲᓐ ᐁᓇᑯᒥᑯᒃ (ᑕᐱᑯ · ᐃᒋᓂᑕ ᐃᑭᒪᑲᓇᓐ, ᐅᑯᒥᓴᓐ) List names and relationship to client

_____

ᐃᐃᒪ ᑲᐃᓂᑕᕐ (ᑭᐱᓐ ᐊᑲᓐ ᐅᑎᓇ: ᐁᒪᑲᓂᑦ ᑲᐃᓂᑕᓂᒃ) **Resides where** (if other than family home)

☐ ᐅᑲᓇ: ᐁᓂᒪ· ᐊ ᑲᐃᓂᑕᕐ Foster home ☐ ᒪᒪᑉ ᑲᓇ: ᐁᕐᕐ· ᐃᓂᑦ Group home (☐ᐊᑲ· ᐁ Short-term ☐ ᑭ· ᓂᑦ Long-term)

☐ ᐅᒪᒪᓂᑲᓇ: ᐁᕐᕐ· ᐃᑲᒥᑦ Detention centre ☐ ᐊᐱᑎᑲᓇ: ᐁᕐᕐ· ᐃᓐ Secure setting ☐ᑕ ᐊ Open

ᑭᐊᑯᐅᑯ· ᐃᓐ Custody setting

☐ ᑭᐊᑯᑎ ᐃᑲᒥᑯᑦ Custody/Detention centre ᐊᑦᑕ ᐃᐃ ᐁ ᐃᑲᒥᑦ Treatment program ☐ ᐁᐁ Yes ☐ ᑲ· ᐃᓐ No ᑯᑕᕐ Other _____

ᐅᑭᑭᓗᑯ· ᐃᓐ School grade _____ ☐ ᐱᒥᑭᑭᓗᕐ· ᐃᓐ Regular ☐ ᑲᐱᒋᓂᑭᕐᑕᓯᓯᒃ ᑭᑭᓗᕐ· ᐃᓐ Special education

☐ ᑲᐱᒥ· ᐃᑐᑲ· ᐃᑉ Day treatment ☐ ᐊᕐᐱᐃᑲᓐ 23 Section 23 ☐ ᑲ· ᐃᓐ ᑭᑭᓗᑯᓯᓯ Not attending

ᐁᓱᑭ· ᖁ ᐅᑕᓯ Client's spoken language(s) ☐ ᕿᑲᓇᕐᒧ English ☐ ᐸ ᑲᐃᕐᒧ French ᑯᑕᕐ Other_____

ᐅᓇᑕ ᐁᑕᓐ ᓇᒋᐊᓐ ᑲᓗᑕ· ᐊᑲᓂ ᐃᑉ ? Interpreter required? ☐ ᐁᐁ Yes ☐ ᑲ· ᐃᓐ No

ᐁᓱᑭ· ᖁ ᐊ ᐅᓂᑭᐃᑯᓐ Parents' spoken language(s) ☐ ᕿᑲᓇᕐᒧ English ☐ ᐸ ᑲᐃᕐᒧ French ᑯᑕᕐ Other _____

☐ ᐊᓐᓂᓇᐅᒧ· ᐃᓐ Aboriginal ☐ ᐊᓐᓂᓇᐅᒧ· ᐃᓐ First Nations ☐ · ᐃᓴᑯᒐ ᐃᓂᓂ Metis ☐ ᐁᑭᒥ Inuit

☐ ᐱᓐᒋᐃᑦᑯᓂᑲᓐ On reserve ☐ ᐊ ᑲᒋᐃᑦᑯᓂᑲᓐ Off reserve

ᒥ· ᑲ ᑎᐊᑯᓂᕐ· ᐃᓂᑦ ᑭᐱᓐᑎᕐᓴ Currently before the courts ☐ ᐁᐁ Yes ☐ ᑲ· ᐃᓐ No ☐ ᑭᐅᓇᑯᓇᑲᓂ ᐃ Sentenced/YJ

ᑎᐊᒋᒧ· ᐃᓐ Explanation _____

ᒐᓴᑲᑭᓄᓱ ᐁᐊᓘᑕᒪᕐ ᐃᓐ ᑲᑭᐅᓯᐸᑭᑎᒃᑲᒐᒃ
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ᐊᒃᓐ ᕿᒍᐅᓇᒐᒃ ᒋ· ᐃᓕᐃᑦ Reason for referral

☐ ᒥᓱ· ᐁᒋᓇᓄᑲᒋᐊᒃᑲᓂ ᐃᑦ Full consult ᐅᓐᒋ re ☐ ᑲ· ᐃᓐᒐᒃ ᐁᓇᐊᖁ Diagnosis ☐ Lᖅᑭᑭ Medication ☐ ᕿᒍᐊᒥ· ᐃᓕᐃᕐᓯᒃ Management

ᑲ· ᕿᒋᒥ· ᐁ ᐃᓇᓐ ᕿᓇᓐ ᕿᒋᑲᒐᒋᓐ ᕿᒍᐅᓇᒐᒃᑲᒃ ᐅ ᐃᓕᐃᑯ· ᐃᓐ (ᒪᔭ ᕿᑯᓇᓐ ᑲ· ᕿᒋᒥ· ᐁᓐ ᑲᔪ ᑕ ᕿᑭᓇᓐ ᑭᖅᐱᓐ ᕿᔭᐱ· ᐃᐅᒍᐱᐊᒪᓐ ᕿᑯᓇᓐ) Questions (be specific)

ᐅᓂᑭᐃᑯᒪᒃ / ᑲᑲᓇ·ᐁᓂᒪ·ᐊᓱ·ᐊᒡ ᐅᒪᒍᔅᓴ·ᐊᕿᑕᒧ·ᐃᓐ (ᑕ·ᕿᑭᓇᓐ ᑭᖅᐱᓐ ᕿᔭᐱ ·ᐃᐅᒍᐱᐊᒪᓐ ᕿᑯᓇᓐ) Parent/Guardian concerns

ᐅᑎᓇᐱᓗ·ᐃᓇᓐ ᑲᔪ ᑲᒪᓂᖅᑲᑯᒡ ᕿᑯᓇᓐ Medical problems and allergies

ᑲᑭᐱᐃᓇᐱᓗ·ᐊᒡ ᐅᑕᓇᒃ ᐃᓇ·ᐁᒪᑲᓇᒃ ᓇᓇᑲᑕ·ᐁᑕᒧ·ᐊᐱᓗ·ᐃᓂᒃ (ᒪᔭ ·ᐃᓐᑕᓐ ᑲᔪ ᑕ·ᕿᑭᓇᓐ ᑭᖅᐱᓐ ᕿᔭᐱ ·ᐃᐅᒍᐱᐊᒪᓐ ᕿᑯᓇᓐ) Family history

ᒐᓪᑲᑲᑭᓄᑦ ᐁᐊᓄᑭᑕᒪᕐ· ᐃᓐ ᑲᑭᐅᑦᐸᑭᑎᑲᑲᒐ
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ᑲᐅᓇᒐ · ᐃᒋᐃᑯ· ᐃᓐ Referral Form

ᕿᑯᓐ ᑲᐃᒍᑭᒋᒪᔪᖅ (ᒐᑭᐱᐊᓐ ᑲᐃᒍᒪᔪᖅ) MAJOR CONCERNS (Check those that apply)

☐ ᑲᐸᕋ ᐊᒐᕐᑲ Developmental Delay ☐ ᐅᒪᒪᓐ ᑲᑭᒥᓂ ᕿᓂᒃ ᒥ· ᑲ ᑭᑭᙵᑲᑯᒃ FAE/FAS ☐ ᑯᑕᒥ ᐁᔪᐸᑎᓇᓂᓂ ᐸᒃᑲ Socialization problems

☐ ᐅᓴᓇᑭᐃᑯᓐ ᐅᑭᑭᓇᑯ· ᐃᓐ School problems ☐ ᐅᑭᑭᓇᑯ· ᐃᓐ Academic ☐ ᐅᑭᓇᑎᕐ· ᐃᓐ Behavioural ☐ ᑲᑭᒥ Truancy ☐ ᑯᑕ Other

☐ ᐅᒐᓂᒥᓯ ᐱᔪᕐ ADHD ☐ ᑲ· ᐃᓐ ᒋᐱᓐᑕ Inattentive ☐ ᓴᓯᑯᒐᑕᑯᓯ Impulsive ☐ ᐅᒐᓂᒥᓯ Hyperactive

☐ ᕐᔪᐱᑕ Oppositional Defiant

☐ ᐊ ᑲᑎᕐ ᐅᑕᐃᑐᑕᒐ· ᐃᓂᒃ Aggressive behaviour ☐ ᐅᑭᑭᑐ ᐃᓂᒃ Verbal ☐ ᐅᑐᑕᒐ· ᐃᓂᒃ Physical ☐ ᑯᑕ Other _____

☐ ᒥᑯᖅᑲᒐᑕ ᐁᔪᐸᑎᓇᓂᓂ ᐸᒃᑲ Antisocial behaviour ☐ ᐅ ᐸᒃᐊᐸᒥᑐ ᕿᑯᓐ Substance abuse ☐ ᒥᓂ ᕿ· ᐃᓐ Alcohol ☐ ᒪᖅᑭᑭ· ᕿ· ᐃᓐ Drug

☐ ᓴᑲᐊ ᐁ Fire setting ☐ ᑯᑕ Other _____

☐ ᐅᑭᐱᑯᓐ ᐅᓇᑯᓂᕿ· ᐃᓐ Conflict with the law ᒪᔭ · ᐃᓐᑕ Please specify_____

☐ ᒪᕐ ᐁ ᐊᑎᕐ Sexual acting out ☐ ᓇᑯᒃ Current ☐ ᐅᑕᓇᒃ Past ᒪᔭ · ᐃᓐᑕ Please specify_____

☐ ᒪᓂᑕᒐ· ᐃᓐ Mood problems ☐ ᒪᓂᑕᒐ· ᐊᐱᓇ Depression ☐ ᐯᐸᑲᓐ ᐊᐃᓂᑕ Mood swings ☐ ᐁᖅᑲᒃ ᐅᓐᒋᒥ· ᓂᑕ Elevated mood

☐ · ᐃᓂᓯᑎᓯ Suicidal behaviours ☐ ᓇᑯᒃ Current ☐ ᐅᑕᓇᒃ Past ᒪᔭ · ᐃᓐᑕ Please specify_____

☐ ᕿᑯᓐ ᑲ· ᕿᑐᑕᓯ Self-harm ᕿᑯᓂ ᑎᓄ ᒪᔭ · ᐃᓐᑕ Type, please specify_____

☐ ᒥᕐᑐᑕᒐ· ᐃᓐ Anxiety ☐ ᑲᓇᓇᐸᐃᓐᑐᑕ Obsessions ☐ ᐁᒥ· ᓂᑕᓯᒃ ᕿᑯᓂ Compulsions ☐ ᑲᑭᑕᒃ Worry

☐ ᑲᑯᑕ ᕿᑯᓐ ᒋᕐᒋᕿᒃ Avoidant behaviour

☐ ᑲᓇᓇᐃᐃᕐᔪᒃ ᕿᑯᓐ Somatization ☐ · ᐁ ᐁᓂᑲᑭᓂᐸᓯᒃ Sleep problems

☐ · ᐁ ᐁᓂᑲᑭ· ᐃᓯᓂᓯᒃ Eating disorder ᒪᔭ · ᐃᓐᑕ Please explain_____

☐ ᑲ· ᐃᒋᑕᒃ ᒪᕐᔪ· ᐃᓐ Family conflict ☐ ᐊᕐ· ᐃᓂᑎ ᐊᑯ ᐅᓂᑭᐃᑯᓐ ᕿᒪ ᐅᑎᓇ ᐁᒪᑲᓇᐃ Separation from parents/family ☐ ᒥᒋᓇ ᐁᕐ· ᐃᓐ Grief

☐ ᑯᑕ Other _____

☐ ᓇᑯᑯ ᐊᐃᕐᕿᕐᕿ Strange, bizarre behaviour ☐ ᑲ· ᐸᐸᑕ ᑲᐃᓂᑕ Hallucinations ☐ ᓇᑯᑯ ᑲᐸᐃᓂᓂᒧᒃ Delusions

☐ ᑭ· ᐸᐸᕐᕿᕐᕿᒋᐃᔪᕐ· ᐃᓂ Witnessed traumatic events ☐ ᐅᕐᒪᑎᕐ· ᐃᓂᒃ Physical ☐ ᒧᕐᔪᐅ·ᐃᓂᒃ Emotional ☐ ᐱᕐ ᑲᒋᐃᑯ· ᐃᓂᒃ Sexual

☐ ᐅᑭᓇᑭᖅᑲᓐ ᑭᒋᐃᔪᕐ· ᐃᓂ Experienced trauma ☐ ᐅᕐᒪᑎᕐ· ᐃᓂᒃ Physical ☐ ᒧᕐᔪᐅ·ᐃᓂᒃ Emotional ☐ ᐱᕐ ᑲᒋᐃᑯ· ᐃᓂᒃ Sexual

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ᐅᑎᕐ· ᐃᑐᑲᑯ· ᐃᓇᓐ Interventions ☐ ᑲ· ᐃᓐ ᒥ· ᑲ · ᐃᑐᑲ· ᐊᕐ None ☐ ᑲ· ᐃᓐ ᐅᑕᓇᒃ ᐸᑲᓐ ᑭᐱᐅᕐ· ᐃᑐᑲ· ᐊᕐ No previous agency involvement

ᑲᑲᓇᕐ ᐁ ᐃᓐ Counselling ☐ · ᐃᓂᑕ Ind ☐ ᐯᕐᑯᒐᕐ· ᐃᓐ Family ☐ ᐅᓂᑭᐃᑯᓐ Parent ☐ LL° Group ☐ ᑯᑕ Other_____

1. ᐅᑎᒥᐅᑕᐱᓇᓐ · ᐃᑐᑲᕿ· ᐃᓂ Specialized program _____

2. ᐅᑕᓇᒃ ᑭᐱᓇᓇᑲᒋᐸᓇᓇᑲᑕ ᐁᑕᒐ· ᐊᐱᓇ ᐃᓂᒃ ᑕᐱᖅᑯ ᐯᐸᑲᓐ ᑲᐃᒋᓇᓇᑲᒋᐃᓐ ᓇᓇᑲᑕ ᐁᑕᒐ· ᐊᐱᓇᓇᓇᑲᒋᐃᑯ· ᐃᓇᓐ (ᑲ· ᐃᓐ · ᐃᓐ ᐃᐃᒪ ᒪᓯᓇᒪᓯᒋᑲᓂᒃ ᑲᐅᕐ· ᐸᐸᒥᒃ ᐅᑕᑯᓯ)

Previous mental health assessments (not Telepsychiatry)

☐ ᑲ· ᐃᓐ No ☐ ᐁᐁ Yes ᐊᐱ Date_____ ᑲᑭᓇᓇᑲᒋᐃᑯᒃ By whom_____
YYYY - MM - DD

ᒐᓕᑲᑭᓄᑦ ᐁᐊᓄᑭᑕᒪᕐ· ᐃᓐ ᑲᑭᐅᑦᐸᑭᑎᑲᒐᒃ
Tele-Mental Health Services, provided by

SickKids® CPRI CHILD & PARENT RESOURCE INSTITUTE CHEO

LAST NAME	(FIRST)
MRN	VISIT NUMBER
DATE OF BIRTH YYYY-MM-DD	SEX
ADDRESS	

IMPRINT OR ENTER DETAILS BY HAND

ᑲᑭᐅᓇᒐᒃ · ᐃᑦᐃᑯ· ᐃᓐ Referral Form

3. ᒥ· ᑲ ᓇ· ᐊᐊᐊᓂᑦ ᕿᒪ ᐅᖅᑲᑎᒃ ᐅᑦᐱᒥ· ᐊ ᐃᑐᒃ· ᐊᑲᑲᓄᑦ ᐁ· ᐃᑐᒃᕿᕐ· ᐃᓂᒃ ᕿᒪ ᓇᓇᑲᑕ ᐁᑕᒧ· ᐊᐱᓐ· ᐃᑐᒃᕿᕐ· ᐃᓂᒃ ?

Involved with other agency or psychiatrist?

_____

4. ᒥ· ᑲ ᑲᐱᒥᐸᐊᑦᑐᒃ ᒪᖅᑭᑭᓐ Current medications

☐ ᐅᒃ · ᐁᑕᒪᖅᑭᑭ Stimulant
ᐁᓂᑲᒐᒃ ᑲᔪᒥᓂᒃ ᐱᒥᐅᑕᐱᓐᒃ : _____
Name & Dosage
ᐁᓂᑲᒐᒃ ᑲᔪᒥᓂᒃ ᐱᒥᐅᑕᐱᓐᒃ : _____
Name & Dosage
ᐁᓂᑲᒐᒃ ᑲᔪᒥᓂᒃ ᐱᒥᐅᑕᐱᓐᒃ : _____
Name & Dosage

☐ ᒪᓕᑕᒧ· ᐊᐱᓇᖅᑭᑭ Anti-depressant
ᐁᓂᑲᒐᒃ ᑲᔪᒥᓂᒃ ᐱᒥᐅᑕᐱᓐᒃ : _____
Name & Dosage
ᐁᓂᑲᒐᒃ ᑲᔪᒥᓂᒃ ᐱᒥᐅᑕᐱᓐᒃ : _____
Name & Dosage
ᐁᓂᑲᒐᒃ ᑲᔪᒥᓂᒃ ᐱᒥᐅᑕᐱᓐᒃ : _____
Name & Dosage

☐ ᒥ· ᓕᑕᒧ· ᐃᒪᖅᑭᑭ Mood stabilizer
ᐁᓂᑲᒐᒃ ᑲᔪᒥᓂᒃ ᐱᒥᐅᑕᐱᓐᒃ : _____
Name & Dosage
ᐁᓂᑲᒐᒃ ᑲᔪᒥᓂᒃ ᐱᒥᐅᑕᐱᓐᒃ : _____
Name & Dosage
ᐁᓂᑲᒐᒃ ᑲᔪᒥᓂᒃ ᐱᒥᐅᑕᐱᓐᒃ : _____
Name & Dosage

☐ ᑭ· ᐊᑭ· ᕿᒪᖅᑭᑭ Anti-psychotic
ᐁᓂᑲᒐᒃ ᑲᔪᒥᓂᒃ ᐱᒥᐅᑕᐱᓐᒃ : _____
Name & Dosage
ᐁᓂᑲᒐᒃ ᑲᔪᒥᓂᒃ ᐱᒥᐅᑕᐱᓐᒃ : _____
Name & Dosage
ᐁᓂᑲᒐᒃ ᑲᔪᒥᓂᒃ ᐱᒥᐅᑕᐱᓐᒃ : _____
Name & Dosage

☐ ᐅᒃᓂᒥᑕᒪᖅᑭᑭ Anti-anxiety
ᐁᓂᑲᒐᒃ ᑲᔪᒥᓂᒃ ᐱᒥᐅᑕᐱᓐᒃ : _____
Name & Dosage
ᐁᓂᑲᒐᒃ ᑲᔪᒥᓂᒃ ᐱᒥᐅᑕᐱᓐᒃ : _____
Name & Dosage
ᐁᓂᑲᒐᒃ ᑲᔪᒥᓂᒃ ᐱᒥᐅᑕᐱᓐᒃ : _____
Name & Dosage

☐ ᑯᑕᕐᔭᓐ ᒪᖅᑭᑭᓐ Other
ᐁᓂᑲᒐᒃ ᑲᔪᒥᓂᒃ ᐱᒥᐅᑕᐱᓐᒃ : _____
Name & Dosage
ᐁᓂᑲᒐᒃ ᑲᔪᒥᓂᒃ ᐱᒥᐅᑕᐱᓐᒃ : _____
Name & Dosage
ᐁᓂᑲᒐᒃ ᑲᔪᒥᓂᒃ ᐱᒥᐅᑕᐱᓐᒃ : _____
Name & Dosage