CTYS central toronto youth services

EMPOWERING YOUTH CHANGING LIVES

Client ID# _____
Program Code: _____

Central Toronto Youth Services - New Outlook Day Program Referral Form

Section A: *Client Information*

Is the client aware of the referral? ☐ Yes ☐ No *Authorization for Disclosure is required for referral*

Name:	D.O.B. (dd/mm/yy):
Address Number / Street /Apt. City Postal Code	
Pronoun(s):	Gender:
Culture(s):	Race:
Primary Language(s):	Would the client like interpretation services? ☐ Yes ☐ No If yes, which language:
Client Contact: (preference ☐ Text ☐ Cell ☐ Email ☐ Voicemail on home phone) Cell: Email: Home:	

Referral Source/Case Manager Information	
Date of Referral	Client consents to service (Day Program) ☐ Yes ☐ No ☐ Internal ☐ External
Worker:	Pronoun(s)
Agency:	Email:
Work Telephone:	Cellular:
Frequency of contact:	

Section B: *Educational History*

OEN #	School Board last attended: ☐ TDSB ☐ TCDSB ☐ ECPP ☐ Other:
What was the last school you attended?	

Grades completed **Check ☑ all that apply**

7	8	9	10	11	12

When did school become challenging?

Always has been	Grades 7-8	Grades 9-10	Grades 11-12	Never has been

Did you have an IEP (Individual Educational Plan)? No ☐ Yes ☐ (Please specify below)	
	Learning exceptionalities -
	Academic accommodations -
	Other:
Documentation	
	Credit Counselling Summary **(required)**
	Psycho-ed assessment
	Supporting documentation / collateral information (**required confirmation of mental health diagnosis**)
	Other:

Which of the following factors contributed to your school challenges? (please indicate all that apply ✓)							
	Learning disability		Peer influences		Bullying		Low motivation
	ADHD/ ADD		Perfectionism		Substance use		Developmental exceptionalities
	MH stigma		Gender Identity		Family dynamics		Impacted by systemic racism
	ASD		Emotional sensitivity		Sensory sensitivity		School avoidance/non-attendance
	Relationship issues		Frustration		Loneliness		Completing tasks/assignments
	Use of electronics		Medical condition		Loss/Grief		Physical exceptionalities
	Transportation		Financial		Marginally housed		Day/Night reversal /sleep issues
	Other:						
Mental Health challenges/diagnosis							
	Depression		Psychosis		Bipolar		Tic Disorder
	Trauma/ PTSD		OCD		Body dysmorphia		Disordered eating
	Social anxiety		General anxiety		Self-harm		Intrusive thoughts
	Other:						

What do you enjoy doing when you are not attending school/ how do you spend your day? (Please indicate all that apply ✓)					
	Watching media - TV/ Movies/ Youtube		Sleeping		Working
	Using technology-internet/ gaming/ social media		Staying at home		Reading
	Being with friends – online		Going into the community		Gym /exercising
	Being with friends - face to face		Taking care of my parent(s)		Baby-sitting/watching my siblings
	Being with family/siblings		Being creative		Listening to music
	Other:				

Wellness strengths and interests: (Please indicate all that apply ✓)					
	Utilizing coping strategies		Respectful of others		Hygiene/self-care
	Engaged in meaningful activities		Positive peer relationships		Follows routines
	Utilizing external resources		Mood & affect regulation		Goal oriented
	Connected to community /culture		Connected to caregivers		Confident
	Able to resolve conflict		Realistic expectations of others		Independent
	Able to express remorse/accept responsibility		Healthy lifestyle		Use of humour
	Utilizing harm reduction strategies		Care for the environment		Good time management

	Hopeful/optimistic		Artistic/musically inclined		Resourceful
	Interested in social justice		Self-advocate		Able to recognize danger
	Self-reflective		Spirituality		
	Other:				

Section C: Preparing for the experience: Please rate your comfort level

Activity/Situation	A current challenge	Uneasy	Somewhat okay	Okay	No problem
Using TTC (subway and buses)					
Attending school everyday					
Arriving at school on time					
Completing school assignments					
Being in a group					
Going to a recreation center					
Other:					

How are you planning to get to the program? ☐ TTC ☐ Driven to school ☐ School Bus

Do you require additional support: ☐ Tokens ☐ School transportation/busing ☐ Building skills to use TTC

Reason for Referral - Outcome of service (☑ all that apply):

☐ Opportunity to connect with peers
☐ Learn about life skills
☐ Support around acquiring academic credits
☐ Health & fitness opportunities
☐ Learn more about mental health
☐ Learn strategies to help me cope better
☐ Increase in coping strategies /improved life skills
☐ Build confidence around using transit
☐ Increase confidence/ greater independence
☐ Addressing systemic racism & barriers (AOP/ABR lens)
☐ Other:

Other needs (links to other services/resources):

☐ Case management ☐ Primary care ☐ Psychiatric care ☐ Social recreation

☐ Community based mental health supports ☐ Busing ☐ Other: _____

Section D: *Health Information*

OHIP#

Allergies/Sensitivities *(include any dietary requirements)*: Epinephrine ("Epi Pen") required? Yes ☐ No ☐

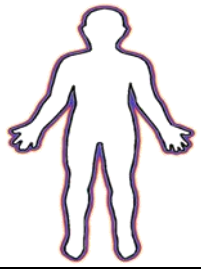
How would you rate your general health: *(Please mark on the line what feels most true for you)*

Poor Fair Good Excellent

Medical information *(include heart/respiratory conditions, seizure disorders or other conditions we should know about)*:

Medication (Type/dose/frequency):

Current Psychiatrist:



Do you have any injuries or parts of your body that cause you pain/discomfort?
(Please circle and explain)

Do you have accessibility needs? (i.e. assistive devices, hearing-aids, etc.)

Risks/Safety Concerns (past & *current*): (please include client's experience of persistent suicidal ideology, suicide attempts, hospitalizations, etc.)

Client Safety Plan on record: ☐ Yes ☐ No (see client Safety Plan and/ or WRAP® Plan)

Date: _____

Section E: *Caregiver/Family/Case Management & Other Community Supports*							
Current living situation							
	Living with parent(s)/caregiver		Supportive housing		Independently		Shelter
	Other:		Group Home		Residential treatment		Foster care

Emergency contact information		
Last Name:	First Name:	
Relationship:	Pronoun(s)	
Address: Number / Street /Apt. City Postal Code		
Home Telephone:	Cellular:	
Email:	Other:	
Cultural Background:	Language(s):	Interpreter required ☐ Yes ☐ No
Other information:		

Other Community Supports	
Name:	
Agency	Pronoun(s)
Work Telephone:	Cellular:
Email:	Other:
Frequency of contact:	
Who are your other supports in the community (i.e. psychiatrist, counsellor, therapist, etc.)	

Please note: *For the purpose of intake, the New Outlook Day Program requires documentation* ***(Credit*** *Counselling Summary, Mental Health supporting documentation, in available - IEP, psych-ed reports).*