|  |
| --- |
| **Central Toronto Youth Services - New Outlook Day Program Referral Form**  🞏 Fall 🞏 Winter 🞏 Summer |
| **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 | | | | | | | | | | | |
|  | Student Status Sheet **(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/Version Code#** | **Expiry Date:** |
| **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):  Side effects of medication: | |
| 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* ***(****Student Status Sheet, Mental Health supporting documentation, in available - IEP, psych-ed reports).*

Day Program Referral Form CT/2025