CTYS central toronto youth services

EMPOWERING YOUTH CHANGING LIVES

NEW OUTLOOK REFERRAL FORM

Program	Nature of Support	Eligibility
Community Support and Intervention Program	Short-term voluntary intensive case management to young adults who are • involved in the criminal justice system (or are at high risk) • have a serious mental illness The support worker will connect clients to crisis services, and arrange psychiatric assessments, links to housing, income support, social and vocational supports, and long-term mental health services.	Participants must • be 16-24 years old and live in Toronto • have a diagnosis of a serious mental illness (if the diagnosis is not clear, CSI can arrange a psychiatric assessment), and • be involved in the criminal justice system, or be at high risk of involvement
Community Support Program	Long-term case management to young people with serious mental illness (psychosis, affective disorders). Through building relationships with our clients, goals are developed that are individualized, flexible and comprehensive. A community support worker collaborates with clients to develop a rehabilitation plan	Participants must • be 16-24 years old and live in Toronto • have received a primary diagnosis of an Axis 1 psychiatric disorder Functional disorders resulting from other issues such as developmental delays or substance abuse must clearly be secondary to the psychiatric diagnosis.
Day Program	Helps young people with serious mental illness (psychosis, affective disorders) to understand and manage their illness. Program mainstays: • life and social skills training • recreation • academic studies in a structured and supportive environment An on-site teacher provides an innovative special education program that allows clients to earn high school credits.	Participants must • be 16-24 years old and live in Toronto • have a diagnosis of a psychotic illness or affective disorder • have no active substance abuse issues • experience significant problems in social and life skill functioning due to the mental illness • have an active case manager/ community support worker
Early Intervention Program	Offers support to young adults experiencing a first episode psychosis. We assist young people aged 15-24 and their families in connecting to mental health services. Through counselling, support, skill building and advocacy, this program helps young people navigate the mental health system.	Participants must • be 15-24 years old and live in Toronto • have experienced a first episode of psychosis, plus a recent marked decline in cognitive and/or social functioning • have less than one year of clinical involvement
Youth Hostel Outreach Program	For young people with serious mental illness who use the shelter system. It supports hard to reach youth who are unlikely to seek out traditional mental health services. YHOP offers psychiatric consultation and assessment as needed and links to mental health services. The goals: reduce the risk of homelessness and connect youth with much needed services	Participants must • be 16-24 years old and live in a shelter • present symptoms of psychosis and • be experiencing serious mental health issues • without formal mental health support No formal diagnosis is necessary.

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Contact: 416-924-2100 Fax: 416-924-2930

For office use only

Has the client been admitted to a Program? Yes **o** No o Program Number:_____

Admission Date:_____ Worker Assigned:_____

Community Support and Intervention ☐ **Community Support Program ☐** **Day Program ☐**

Early Intervention ☐ **Youth Hostel Outreach Program ☐**

Referral Source Information

Referral Date: _____

Name:_____

Agency:_____

Address:_____
Address City Postal Code

Telephone: _____ Extension:_____

Client Information

Gender: _____

Last Name:_____ First Name:_____

Address:_____
Number Street Name City Postal Code

Home Tel. Number:_____ Other Contact Number:_____

Date of Birth (DD/MM/YYYY):_____ Age:_____

Cultural Background:_____ Birthplace:_____

Language(s):_____ Immigration / Citizenship / Status:_____

S.I.N.:_____ Health Card #:_____
Optional

Education/Employment:_____

History of Homelessness:_____

Emergency Contact Information

1. Name:_____ Relation:_____

Address:_____
Number Street Name City Postal Code

Home Tel. Number:_____ Cellular Number:_____

Bus. Tel. Number:_____ Extension:_____

2. Name:_____ Relation:_____

Address:_____
Number Street Name City Postal Code

Home Tel. Number:_____ Cellular Number:_____

Bus. Tel. Number:_____ Extension:_____

Client Contacts

General Practitioner: _____

Address: _____ Telephone Number: _____

Describe any medical conditions or allergies and include any related medication, treatment, and/or physicians involved: _____

_____

_____

Lawyer: _____

Address: _____ Telephone Number: _____

Provide legal history/pending charges: _____

_____

_____

_____

_____

Psychiatrist: _____

Address: _____ Telephone Number: _____

Frequency of contact/Length of contact: _____

Primary Diagnosis: _____

By Whom: _____ Tel #: _____ Date: _____

Concurrent Disorder? Yes **o** No o

Comments: _____

_____

_____

_____

Developmental Delay? Yes **o** No o

Comments: _____

_____

_____

_____

Mental health diagnosis: _____

_____

_____

_____

Presenting Issues:

Symptoms (check all that apply):

Hearing Voices	☐	Paranoia	☐	Talking to themselves	☐
Delusions (firm false beliefs)	☐	Ideas of grandeur	☐	Intensified mood swings	☐
Agitation / Restlessness	☐	Depression	☐	Sleep Disturbances	☐
Isolates	☐	Suicidal Ideation	☐	Homicidal Ideation	☐

Indicators the client is becoming ill: _____

_____

_____

_____

Medications:

Name	Dosage & Frequency	Administered By	Compliance

Prescribed by:_____

Psychiatric History

1. First Psychiatric Admission (place, date, duration): _____

2. List the two most recent admissions**:**

Hospital	**Dates of Stay**	**Reason for Hospitalization**	**Discharge Diagnosis**

History of Trauma or Sexual Abuse Yes **o** No o

How has this been addressed?_____

History of aggression:

Toward self ☐ Toward others ☐ Toward property ☐ Sexual Assault ☐

_____

History of substance abuse:_____

List other agencies/services the client is or has been involved with, including dates of involvement. (i.e. Housing, educational, vocational) with contact person and telephone number:

Agency	**Contact Person**	**Telephone number**	**Dates of Involvement**

Is Client Aware of Referral? Yes **o** No o

_____ _____

Signature of Referral Source **Date**

*Attach any relevant assessments, summaries or documents which may support this referral

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AUTHORIZATION FOR THE DISCLOSURE, TRANSMITTAL OR EXAMINATION OF CONFIDENTIAL INFORMATION

This form authorizes the release/mutual release (circle one) and sharing of confidential information to/between Central Toronto Youth Services and:

_____

(Print Name of Person, Agency or Institution)

I/We hereby authorize release of confidential information about myself/the person(s) noted below, either verbal or contained in the written record of:

_____ Male ☐ Female ☐

(Print Name of Client) D.O.B.(mm/dd/yyyy)

Type of Information (check ✓ all that apply)

- ☐ All relevant information
- ☐ Intake Information
- ☐ Summary of Services
- ☐ Other (please specify): _____
- ☐ Psychological Assessment Report
- ☐ Psychiatric Mental Status

This information is to be disclosed fro the purpose of: (check ✓ all that apply)

- ☐ Psychological Assessment
- ☐ Service Coordination
- ☐ Psychiatric Mental Status
- ☐ Other(please specify): _____
- ☐ Intake Information Only
- ☐ Assessment/Treatment Planning

Form prepared by: _____

(Name of Agency) (Name of Staff Person)

☐ Check ✓ here if verbal consent was obtained via the telephone.

Staff witness to verbal consent _____

AUTHORIZATION SIGNATURES

Subject of Information (print names of "self" or "client and family" etc.)	Authorizing Person (print name)	Relationship to Client	Signature of Authorizing Person	Signature of Witness	Date

Expiry Date: _____ *[*Maximum is one year*]

***Authorizing person(s) may cancel or change the above authorization(s) in writing at any time prior to the expiry date, unless action already has been taken on the basis of the authorization(s).** CTYS / May 2007

(Instructions for completing this page appear on next page)

INSTRUCTIONS FOR COMPLETING THIS FORM

1. Authorization must be in writing* and contain the signature of the subject(s) of the information, or the legal representation of the subject(s), as well as the signature of a witness. One person may witness more than one signature.

2. The service provider may serve as a witness.

3. Authorization must be given by a person who is mentally capable of making the decision to disclose the information. The following guidelines may be helpful:

    a. Persons aged 16 or over may be presumed capable of authorizing the release of confidential information about themselves, unless there are reasonable grounds to question this presumption;
    b. Authorization for the release of confidential information about persons under the age of 16 (with the three following exceptions) must be obtained from a custodial parent or legal guardian;
    c. Children 12 years of age or older who receive services under Section 28 of the CFSA (i.e., without parental consent) must authorize release of confidential information about themselves obtained during the provision of services under that Section;
    d. Confidential information should not be released about children under the age of 16 who object to the release and who are deemed capable with regard to the release decision;
    e. Children under the age of 16 who request, on their own behalf, release of confidential information about themselves may authorize such release if they are deemed capable of doing so.

4. It is necessary to obtain authorization from all capable persons currently 16 or older before releasing their confidential information, regardless of their age at the time of service or their relationship to the client.

5. Authorization to release confidential information does not prevent the withholding of information that is judged likely to result in serious harm to the treatment or recovery of the client, or serious physical or serious emotional harm to another person. Absence of authorization does not prevent the release of information for the purpose of reporting that a child is or may be in need of protection.

6. Please identify as precisely as possible the purpose of the disclosure (e.g. “treatment planning”, “assessment”, “so-ordination of services”) and the nature of the confidential information to be disclosed (e.g. “all relevant information”, “intake information only”, “psychological assessment report”, “summary of service”).

*** In an emergency, or urgent or extraordinary situations where obtaining a written signature is not possible, a staff person should obtain verbal consent and have the verbal consent witnessed by another staff person. Every effort should then be made subsequently to follow up with the client/parent/guardian/legal representative to obtain a signature on the form.**