

Application Form Coordinated Referral-Day Treatment

Please note that, if all the required documentation is not included and/or consents are not signed and initialed, the presentation will not be scheduled.

- Consent Forms - signed and initialed by parent(s)/guardian(s), and youth if 16 years' old
(Note: in a shared care agreement both guardians must complete and sign the consent forms)
- Parent/guardian Information Guide has been reviewed with and giving to parent/guardian
- Ottawa Children's Coordinated Access and Referral to Services Application Form
- Assessments (completed within 2 years) relating to the following: Academic functioning, Socio-emotional, Cognitive abilities
- Current Report Card, Individual Education Plan and Credit Counseling Summary Speech and Language Evaluation, Occupational / Physical Therapy Assessment (if available)
- Social History, Social Work, Plans of Care, Safety Plan (if available)

NOTE:

The responsibility of presenting the file/case to the Ottawa Children's Coordinated Access and Referral to Services' Committee remains with the agency/school asking for services. We do encourage the presenters to be accompanied by people who know the child/youth well, for example: other agency, family members, doctors, specialists, psychiatrists, etc.

If the request is not from an Ottawa School Board, a copy of the complete file, including this copy, need to be sent by mail, confidential fax or encrypted e-mail to:

Ottawa Children's Coordinated Access & Referral to Services
2675 Queensview Drive, Ottawa, ON, K2B 8K2
(613) 729-0577 ext. 1251
Fax: (613) 288-0426
info@coordinatedaccess.ca

Student name:

Presenter(s) & attendee(s)

Name	Title	School/agency	E-mail address	Phone number
				() -
				() -
				() -
				() -
				() -
				() -

Completed form is to be submitted with the package

CONSENT TO THE DISCLOSURE, TRANSMITTAL OR EXAMINATION OF CLINICAL RECORD AND REPORT CARD

(The parent or guardian must sign the consent form on behalf of children under the age of 16. Whenever possible, children between the ages of 12 and 15 should also sign their own consent form).

I (*last & first name of parent/guardian*), _____ of
 (*address*) _____ hereby consent to the release, disclosure or transmittal to and
 examination by any member of Ottawa Children's Coordinated Access and Referral to Services Committee of
 the following information in respect to (*last & first name of client*): _____
 and (*date of birth*) _____.

OR,

(Children 16 years of age or older must sign their own consent forms).

I (*last and first name of client*), _____, (*date of birth*) _____
 hereby consent to the release, disclosure or transmittal to and examination by any member of Ottawa Children's
 Coordinated Access and Referral to Services Committee of the following information:

Educational Records Clinical records compiled in or at: _____
(list the name(s) of agency, facility or private practitioner)

Description of the information to be disclosed from the Clinical Records:

Medical Records Needs Assessment Psychiatric/Psychological Records
 Social history Educational records Behavioral assessment
 Intake Forms Risk assessment Other Pertinent Information, specify:

I understand that this consent is also for the purpose of collecting information for research to help understand the factors involving mental health services and clients. The information collected will remain confidential, will be coded and the client will not be identified by name. My consent means that I agree to allow information about the client, which does not identify the client by name, to be included in research on mental health services and clients. Names of clients and/or guardians and/or parents will not be associated in any way with the results of the research.

NOTE:

1. A client who is 12 years of age or older, who has participated in counselling with or without parental/guardian consent may, with or without parental/guardian consent to the release, disclosure or transmittal to and examination of their counselling records.
2. Consent to residential and day treatment services may only be given by the parent/guardian if the client has not attained the age of 16 years.
3. Consent to residential and day treatment services may only be given to the client, with or without parental/guardian consent, where the client has attained the age of 16 years.
4. A client who is 16 years of age or older may, with or without parental/guardian consent, consent to the release, disclosure or transmittal to and examination of his/her personal information.

This authorization for the release, disclosure or transmittal and examination of the above-described information has been fully explained to me. I understand and agree with the disclosure.

 (*Signature of client, if applicable*)

 Date

 (*Signature of parent/guardian*)

 Date

 (*Signature of witness*)

 Date

CONSENT TO PARTICIPATE IN THE COORDINATED ACCESS MECHANISM

(The parent or guardian must sign the consent form on behalf of children under the age of 16. Whenever possible, children between the ages of 12 and 15 should also sign their own consent form).

I (last & first name of parent/guardian), _____ hereby consent to receive case resolution / referral services from the Ottawa Children's Coordinated Access and Referral to Services in respect to (last & first name of client), _____ (date of birth) _____.

OR,
(Children 16 years of age or older must sign their own consent forms)

I (last & first name of client), _____ (date of birth) _____ hereby consent to receive case resolution / referral services from the Ottawa Children's Coordinated Access and Referral to Services.

- ▶ I understand that all the information provided to the Ottawa Children's Coordinated Access and Referral will be shared with all committee members unless otherwise indicated.
- ▶ I consent to the disclosure of my service history and that of my family from the following organizations for the purpose of the Ottawa Children's Coordinated Access and Referral to Services' presentation. Please indicate below if you do not consent to an agency sharing your service history.
- ▶ I understand that this consent is for the purpose of developing recommendations regarding admission and/or referrals to mental health services, day treatment and residential care. However, the least intrusive measure possible will be developed.

I am aware that the following organizations participate in the Ottawa Children's Coordinated Access and Referral to Services Committee and consent to their participation.

Please indicate by a check mark if you **DO NOT CONSENT** to the participation of an agency listed below.

- | | |
|--|---|
| <input type="checkbox"/> Association pour l'intégration sociale d'Ottawa | <input type="checkbox"/> Ottawa Children's Treatment Centre/CHEO |
| <input type="checkbox"/> Centre Psychosocial | <input type="checkbox"/> Ottawa Inuit Centre |
| <input type="checkbox"/> Champlain Local Health Integration Network (LHIN) | <input type="checkbox"/> Ottawa Rotary Home |
| <input type="checkbox"/> Children's Aid Society of Ottawa | <input type="checkbox"/> Rideauwood Addiction and Family Services |
| <input type="checkbox"/> Children's Hospital of Eastern Ontario | <input type="checkbox"/> Roberts/Smart Centre |
| <input type="checkbox"/> Conseil des écoles catholiques du Centre-Est de l'Ontario | <input type="checkbox"/> Roger Neilson House |
| <input type="checkbox"/> Conseil des écoles publiques de l'Est de l'Ontario | <input type="checkbox"/> Royal Ottawa Mental Health Centre |
| <input type="checkbox"/> Crossroads Children's Mental Health Centre | <input type="checkbox"/> Service Coordination des services |
| <input type="checkbox"/> Dave Smith Youth Treatment Centre | <input type="checkbox"/> Wabano Centre for Aboriginal Health |
| <input type="checkbox"/> Maison Fraternité | <input type="checkbox"/> Youth Services Bureau |
| <input type="checkbox"/> Ministry of Children, Community and Social Services | <input type="checkbox"/> Youturn Youth Support Services |
| <input type="checkbox"/> Ministry of Health and Long-Term Care | |
| <input type="checkbox"/> Ministry of Community Safety and Correctional Services | |
| <input type="checkbox"/> Ottawa-Carleton Association for Persons with Developmental Disabilities | |
| <input type="checkbox"/> Ottawa Catholic School Board | |
| <input type="checkbox"/> Ottawa Carleton District School Board | |

Other agencies for which you are providing consent to participate: specify

(Signature of client, if applicable)

Date

(Signature of parent/guardian)

Date

(Signature of Witness)

Date

COORDINATED ACCESS MECHANISM

- I understand that if the committee recommends a referral to an agency working with Ottawa Children's Coordinated Access and Referral to Services they would be provided with a copy of the documentation gathered for the presentation and the committee's recommendations.
- I am aware that, following my consent, a file is opened with the Ottawa Children's Coordinated Access and Referral to Services. The information gathered will remain the property of Coordinated Access and Referral for ten years after the last contact and will be archived at the Youth Services Bureau of Ottawa.
- I am aware that the file will be kept confidential. A copy of the information gathered will be kept in the file, as well as on the Youth Services Bureau of Ottawa's confidential database.
- I have been given and have reviewed the "Client - Parent/Guardian information guide" that includes information about my rights, responsibilities, risks, benefits and appeal process related to Ottawa Children's Coordinated Access and Referral to Services.
- I have been made aware that I have the right to refuse any recommendations/referrals to services made by the Ottawa Children's Coordinated Access and Referral to Services Committee.
- I understand that there are three circumstances that would require the Ottawa Children's Coordinated Access and Referral to Services Committee to report information without my consent. They are,
 1. If the committee were told that someone is planning to seriously harm someone.
 2. Under the law, if the committee believes that a child under the age of 18 is at risk of harm we must report this to the Children's Aid Society.
 3. If there is a court case and the judge demands it, Ottawa Children's Coordinated Access and Referral to Services must release the file to the judge who will decide if any of the information is relevant to the trial.

I agree to be contacted by Ottawa Children's Coordinated Access and Referral to Services in order to give feedback about my level of satisfaction with the process and the services I have received (please fill out contact information below).

Telephone: (_____) _____ - _____ E-mail: _____

I have read and agree with all of the above information. I understand the information given and know my rights and responsibilities.

(Signature of client, if applicable)

Date

(Signature of parent/guardian)

Date

(Signature of Witness)

Date

INTAKE FACT SHEET

Referral source / School board			
Student's school		Grade:	
Number of school credits	<input type="checkbox"/> N/A		
Presenters			
Name:	Role:	Telephone:	E-mail:
		() - ext	
		() - ext	
		() - ext	
Service requested	<i>Day Treatment Program</i>		

Child/Youth & Family Information

Child/youth's name			
Date of birth (m/d/y)		Age:	
Parent/guardian			
Address			Postal Code:
Telephone	Home	() -	Work: () -
	Email		
Parent/guardian			
Address			Postal Code:
Telephone	Home	() -	Work () -
	E-mail		
Sibling(s)	Name	Date of birth	School

Health Information

Diagnosis / Health concerns			
Family physician	Name		
	Telephone		
Specialist (s)	Name	Specialty	Telephone
			() -
			() -
			() -
Medication	Prescribed by		Date of last review

Diagnosis Information

Diagnosis	Diagnosing professional	Date (dd/mm/yy)
<input type="checkbox"/> Attention Deficit Disorder		
<input type="checkbox"/> Attention Deficit Disorder with Hyperactivity		
<input type="checkbox"/> Attachment Disorder		
<input type="checkbox"/> Adjustment Disorder		
<input type="checkbox"/> Communication Disorder		
<input type="checkbox"/> Depression		
<input type="checkbox"/> Anxiety Disorder: Please specify:		
<input type="checkbox"/> Obsessive Compulsive Disorder		
<input type="checkbox"/> Bipolar Disorder		
<input type="checkbox"/> Tourette Syndrome		
<input type="checkbox"/> Conduct Disorder		
<input type="checkbox"/> Oppositional Defiant Disorder		
<input type="checkbox"/> Autism Spectrum Disorder Specify:		
<input type="checkbox"/> Other diagnosis Specify:		

School Status

Number of school attended: <i>Please list:</i>	Grade failed:
	History of Absenteeism (days missed by school year): Comment:
Number of credits:	IPRC Status: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Exceptionality:
Does child/youth currently attend school? <input type="checkbox"/> Yes <input type="checkbox"/> No, expelled <input type="checkbox"/> Excluded <input type="checkbox"/> No, suspended <input type="checkbox"/> Safe School <input type="checkbox"/> No, other; specify: <input type="checkbox"/> On waiting list for:	Does the child/youth currently have a school placement? <input type="checkbox"/> Yes, regular class placement <input type="checkbox"/> Yes, special education placement; specify: _____ <input type="checkbox"/> Yes, modified day; specify: _____ <input type="checkbox"/> Yes, other; specify: _____ <input type="checkbox"/> No: specify _____ <input type="checkbox"/> Unknown
Areas of Strength (subject)	Areas of Need (subject)
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.

DEMOGRAPHIC INFORMATION

Demographic information	
<p>Sex of Client <i>What sex were you assigned at birth?</i></p> <p><input type="checkbox"/> Male <input type="checkbox"/> Intersex <input type="checkbox"/> Female <input type="checkbox"/> Prefer not to answer</p>	<p>Gender Identity <i>What is your current gender identity?</i></p> <p><input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Two Spirit <input type="checkbox"/> A gender (does not identify as male, female or Transgender) <input type="checkbox"/> Gender fluid / Non-binary (varies day to day) <input type="checkbox"/> Trans Male (born female transitioning to male) <input type="checkbox"/> Trans Female (born male transitioning to female) <input type="checkbox"/> Other (please specify): <input type="checkbox"/> Prefer not to answer</p>
<p>Sexual Orientation of Client <i>What is your sexual orientation?</i></p> <p><input type="checkbox"/> Asexual <input type="checkbox"/> Gay <input type="checkbox"/> Lesbian <input type="checkbox"/> Bisexual <input type="checkbox"/> Queer <input type="checkbox"/> Heterosexual <input type="checkbox"/> Two-spirited <input type="checkbox"/> Other (please specify): <input type="checkbox"/> Prefer not to answer</p>	<p>Client Legal Guardianship <i>Who is client's legal guardian?</i></p> <p><input type="checkbox"/> Both parents <input type="checkbox"/> Mother only <input type="checkbox"/> Father only <input type="checkbox"/> Neither parent but other relative(s) or non-relative(s) <input type="checkbox"/> Parental-CAS (Temporary Care Agreement) • Specify Who: _____ <input type="checkbox"/> Children's Aid Society - Crown Ward <input type="checkbox"/> Children's Aid Society - Society or Temporary Ward <input type="checkbox"/> Children's Aid Society - Interim Care and custody <input type="checkbox"/> Public Guardian <input type="checkbox"/> Independent - Youth responsible for self <input type="checkbox"/> Other – Specify: _____</p> <p><i>Copy of legal guardianship obtained?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> No but declaration/guardianship form signed</p>
<p>Current living situation <i>Who are you currently living with?</i></p> <p><input type="checkbox"/> With parent(s) or guardian(s) <input type="checkbox"/> With sibling(s), no parent(s)/guardian(s) <input type="checkbox"/> Other relative(s) <input type="checkbox"/> Foster family <input type="checkbox"/> Group home <input type="checkbox"/> Friends <input type="checkbox"/> Independent <input type="checkbox"/> Other (please specify) _____ <input type="checkbox"/> Prefer not to answer</p>	<p>Family Income <i>What was your total family income last year?</i></p> <p><input type="checkbox"/> \$0 to \$29,999 <input type="checkbox"/> \$120,000 to \$149,999 <input type="checkbox"/> \$30,000 to \$59,999 <input type="checkbox"/> \$150,000 or more <input type="checkbox"/> \$60,000 to \$89,999 <input type="checkbox"/> Prefer not to answer <input type="checkbox"/> \$90,000 to \$119,999 <input type="checkbox"/> Do not know</p> <p>How many people does this income support?</p>
<p>Language <i>What is your mother tongue?</i></p> <p><input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> Other</p> <p><i>In which language, would you like to receive service?</i></p> <p><input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> Other (please specify): _____</p> <p><i>Are you comfortable speaking with your care provider in English or French?</i></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No, but have resources / supports to provide interpretation</p>	<p><i>If discrepancy between mother tongue, child/youth's educational language and preferred language of service, please explain:</i></p> <p><input type="checkbox"/> Perception that quality of service is different <input type="checkbox"/> Perception that wait times are different <input type="checkbox"/> Uni-lingual family member <input type="checkbox"/> Other (please specify): _____</p> <p><i>Are you comfortable receiving written information in English or French?</i></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No, but have resources / supports to provide interpretation</p>

Demographic information				
<p>Accessibility Do you identify as a person with one or more disabilities?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Prefer not to answer</p> <p><i>If yes, check all that apply:</i></p> <p><input type="checkbox"/> Seeing <input type="checkbox"/> Hearing <input type="checkbox"/> Mobility <input type="checkbox"/> Flexibility <input type="checkbox"/> Dexterity <input type="checkbox"/> Pain <input type="checkbox"/> Learning <input type="checkbox"/> Memory <input type="checkbox"/></p> <p>Developmental <input type="checkbox"/> Drug or alcohol dependence <input type="checkbox"/> Mental/psychological <input type="checkbox"/> None of the above (please specify): _____</p>	<p>Language What language(s) is spoken at home?</p> <table style="width: 100%; border: none;"> <tr> <td style="vertical-align: top; width: 33%;"> <p>Child/youth</p> <input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> Arabic <input type="checkbox"/> Cantonese <input type="checkbox"/> Chinese, n.o.s. <input type="checkbox"/> German <input type="checkbox"/> Indigenous Language <input type="checkbox"/> Mandarin <input type="checkbox"/> Persian (Farsi) <input type="checkbox"/> Portuguese <input type="checkbox"/> Somali <input type="checkbox"/> Spanish <input type="checkbox"/> Italian <input type="checkbox"/> Prefer not to answer <input type="checkbox"/> Other: _____</td> <td style="vertical-align: top; width: 33%;"> <p>Caregiver 1</p> <input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> Arabic <input type="checkbox"/> Cantonese <input type="checkbox"/> Chinese, n.o.s. <input type="checkbox"/> German <input type="checkbox"/> Indigenous Language <input type="checkbox"/> Mandarin <input type="checkbox"/> Persian (Farsi) <input type="checkbox"/> Portuguese <input type="checkbox"/> Somali <input type="checkbox"/> Spanish <input type="checkbox"/> Italian <input type="checkbox"/> Prefer not to answer <input type="checkbox"/> Other: _____</td> <td style="vertical-align: top; width: 33%;"> <p>Caregiver 2</p> <input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> Arabic <input type="checkbox"/> Cantonese <input type="checkbox"/> Chinese, n.o.s. <input type="checkbox"/> German <input type="checkbox"/> Indigenous Language <input type="checkbox"/> Mandarin <input type="checkbox"/> Persian (Farsi) <input type="checkbox"/> Portuguese <input type="checkbox"/> Somali <input type="checkbox"/> Spanish <input type="checkbox"/> Italian <input type="checkbox"/> Prefer not to answer <input type="checkbox"/> Other: _____</td> </tr> </table>	<p>Child/youth</p> <input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> Arabic <input type="checkbox"/> Cantonese <input type="checkbox"/> Chinese, n.o.s. <input type="checkbox"/> German <input type="checkbox"/> Indigenous Language <input type="checkbox"/> Mandarin <input type="checkbox"/> Persian (Farsi) <input type="checkbox"/> Portuguese <input type="checkbox"/> Somali <input type="checkbox"/> Spanish <input type="checkbox"/> Italian <input type="checkbox"/> Prefer not to answer <input type="checkbox"/> Other: _____	<p>Caregiver 1</p> <input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> Arabic <input type="checkbox"/> Cantonese <input type="checkbox"/> Chinese, n.o.s. <input type="checkbox"/> German <input type="checkbox"/> Indigenous Language <input type="checkbox"/> Mandarin <input type="checkbox"/> Persian (Farsi) <input type="checkbox"/> Portuguese <input type="checkbox"/> Somali <input type="checkbox"/> Spanish <input type="checkbox"/> Italian <input type="checkbox"/> Prefer not to answer <input type="checkbox"/> Other: _____	<p>Caregiver 2</p> <input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> Arabic <input type="checkbox"/> Cantonese <input type="checkbox"/> Chinese, n.o.s. <input type="checkbox"/> German <input type="checkbox"/> Indigenous Language <input type="checkbox"/> Mandarin <input type="checkbox"/> Persian (Farsi) <input type="checkbox"/> Portuguese <input type="checkbox"/> Somali <input type="checkbox"/> Spanish <input type="checkbox"/> Italian <input type="checkbox"/> Prefer not to answer <input type="checkbox"/> Other: _____
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<p>Legal status in Canada:</p> <input type="checkbox"/> Citizen <input type="checkbox"/> Temporary resident <input type="checkbox"/> Dual citizen <input type="checkbox"/> Permanent resident <input type="checkbox"/> Refugee <input type="checkbox"/> Prefer not to answer What year did you arrive in Canada? _____ <input type="checkbox"/> Prefer not to answer	<p>Place of Origin Where were you born:</p> <input type="checkbox"/> Canada <input type="checkbox"/> Born outside of Canada Specify country: _____			
<p>Which race do you identify with (choose all that apply):</p> <input type="checkbox"/> Arab <input type="checkbox"/> Black <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> White <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Latin American <input type="checkbox"/> Indigenous <input type="checkbox"/> West Asian (e.g. Iranian, Afghan, etc.) <input type="checkbox"/> South Asian (e.g. East Indian, Pakistani, Sri Lankan etc.) <input type="checkbox"/> Southeast Asian (e.g. Vietnamese, Cambodian, Thai, etc.) <input type="checkbox"/> Other – specify: _____ <input type="checkbox"/> Prefer not to answer	<p>Indigenous Population Please indicate which cultural group best represents your identity, or portion of your identity:</p> <input type="checkbox"/> First Nations – Community: <input type="checkbox"/> Cree <input type="checkbox"/> Mohawk <input type="checkbox"/> Ojibway <input type="checkbox"/> Mi'kmaq <input type="checkbox"/> Algonquin <input type="checkbox"/> Other (please specify): _____ <input type="checkbox"/> Métis – Community: _____ <input type="checkbox"/> Inuit – Region/Community: _____ <input type="checkbox"/> Other (please specify): _____ <input type="checkbox"/> Prefer not to answer <input type="checkbox"/> N/A			
<p>Ethnicity Which ethnic/ cultural group do you identify with (check all that apply):</p> <table style="width: 100%; border: none;"> <tr> <td style="vertical-align: top; width: 50%;"> <input type="checkbox"/> North American (Canadian, American, Mexican) <input type="checkbox"/> British Isles (English, Irish, Scottish, Welsh) <input type="checkbox"/> West Asian (Afghan, Armenian, Iranian, Israeli, Turk) <input type="checkbox"/> Western European (Austrian, Belgian, Dutch, German, Swiss) <input type="checkbox"/> Northern European (Danish, Finnish, Icelandic, Norwegian, Swedish) <input type="checkbox"/> Eastern European (Czech, Hungarian, Latvian, Lithuanian, Polish, Romanian, Russian, Slovak, Ukrainian) <input type="checkbox"/> Southern European (Bulgarian, Croatian, Greek, Italian, Portuguese, Serbian, Slovenian, Spanish) <input type="checkbox"/> Caribbean (Barbadian, Guyanese, Haitian, Indo-Caribbean, Jamaican, Trinidadian/Tobagonian, West Indian) <input type="checkbox"/> Latin, Central South American origins (Colombian, Mexican, Peruvian, Salvadorian) <input type="checkbox"/> African (Black, Burundian, Congolese, Eritrean, Ethiopian, Ghanaian, Nigerian, Rwandan, Somali, South African) <input type="checkbox"/> South Asian (Bangladeshi, East Indian, Pakistani, Punjabi, Sri Lankan, Tamil) <input type="checkbox"/> East/Southeast Asian (Cambodian, Chinese, Filipino, Japanese, Korean, Vietnamese) </td> <td style="vertical-align: top; width: 50%;"> <input type="checkbox"/> French (Acadian, French) <input type="checkbox"/> Other European (Jewish) <input type="checkbox"/> Indigenous </td> </tr> </table>		<input type="checkbox"/> North American (Canadian, American, Mexican) <input type="checkbox"/> British Isles (English, Irish, Scottish, Welsh) <input type="checkbox"/> West Asian (Afghan, Armenian, Iranian, Israeli, Turk) <input type="checkbox"/> Western European (Austrian, Belgian, Dutch, German, Swiss) <input type="checkbox"/> Northern European (Danish, Finnish, Icelandic, Norwegian, Swedish) <input type="checkbox"/> Eastern European (Czech, Hungarian, Latvian, Lithuanian, Polish, Romanian, Russian, Slovak, Ukrainian) <input type="checkbox"/> Southern European (Bulgarian, Croatian, Greek, Italian, Portuguese, Serbian, Slovenian, Spanish) <input type="checkbox"/> Caribbean (Barbadian, Guyanese, Haitian, Indo-Caribbean, Jamaican, Trinidadian/Tobagonian, West Indian) <input type="checkbox"/> Latin, Central South American origins (Colombian, Mexican, Peruvian, Salvadorian) <input type="checkbox"/> African (Black, Burundian, Congolese, Eritrean, Ethiopian, Ghanaian, Nigerian, Rwandan, Somali, South African) <input type="checkbox"/> South Asian (Bangladeshi, East Indian, Pakistani, Punjabi, Sri Lankan, Tamil) <input type="checkbox"/> East/Southeast Asian (Cambodian, Chinese, Filipino, Japanese, Korean, Vietnamese)	<input type="checkbox"/> French (Acadian, French) <input type="checkbox"/> Other European (Jewish) <input type="checkbox"/> Indigenous	
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CURRENT PRIMARY PRESENTING PROBLEMS AREAS:

Check category that apply; choose as many as apply.

<p>School and Learning</p> <p><input type="checkbox"/> Lack of support</p> <p><input type="checkbox"/> School Phobia</p> <p><input type="checkbox"/> Academic under Achievement</p> <p><input type="checkbox"/> Learning Problems</p> <p><input type="checkbox"/> Specific Learning Disability</p> <p><input type="checkbox"/> Transportation challenges</p> <p><input type="checkbox"/> Other – specify: _____</p>	<p>Victimization</p> <p><input type="checkbox"/> Sexual Abuse <input type="checkbox"/> Physical Abuse <input type="checkbox"/> Emotional Abuse</p> <p><input type="checkbox"/> Reported Abuse; to: _____</p> <p>By whom: _____</p> <p><input type="checkbox"/> Bullying/Threat; reported to: _____</p> <p>By whom: _____</p> <p><input type="checkbox"/> Witness of abuse</p> <p><input type="checkbox"/> Neglect</p> <p><input type="checkbox"/> Exploited</p>
<p>Disruptive Behavior</p> <p><input type="checkbox"/> Interfering /Challenging Behavior</p> <p> <input type="checkbox"/> School <input type="checkbox"/> Community <input type="checkbox"/> Home</p> <p><input type="checkbox"/> Running</p> <p><input type="checkbox"/> Fire Setting</p> <p><input type="checkbox"/> Stealing</p> <p><input type="checkbox"/> Destruction of Property</p> <p><input type="checkbox"/> Sexual Acting Out</p> <p><input type="checkbox"/> Substance Abuse</p> <p><input type="checkbox"/> Defiance</p> <p><input type="checkbox"/> Problems with Self Control</p> <p><input type="checkbox"/> Bullying</p> <p><input type="checkbox"/> Hostility with Aggression</p> <p><input type="checkbox"/> Hostility without Aggression</p>	<p>Thought, Perception and Mood</p> <p>Disturbances</p> <p><input type="checkbox"/> Disturbances in Thought Process</p> <p><input type="checkbox"/> Anxiety</p> <p><input type="checkbox"/> Continued Excited Mood</p> <p><input type="checkbox"/> Self Harm</p> <p><input type="checkbox"/> Labile Mood</p> <p><input type="checkbox"/> Suicidal Ideation</p> <p><input type="checkbox"/> Suicidal Gestures</p> <p><input type="checkbox"/> Depression</p> <p>Intellectual/Adaptive/Functional</p> <p><input type="checkbox"/> Deficits in Intellectual Function</p> <p><input type="checkbox"/> Deficits in Life Skills</p> <p><input type="checkbox"/> Development Delay</p>
<p>Physical/Sensory Status</p> <p><input type="checkbox"/> Neurological or Severe Brain Damage</p> <p><input type="checkbox"/> Enuresis</p> <p><input type="checkbox"/> Encopresis</p> <p><input type="checkbox"/> Sensory Deficits/Disorders</p> <p><input type="checkbox"/> Sleep Disturbances</p> <p><input type="checkbox"/> Psycho-Physiological</p> <p><input type="checkbox"/> Physical Disability</p> <p><input type="checkbox"/> Mobility Challenges</p> <p><input type="checkbox"/> Incontinence</p> <p><input type="checkbox"/> Visual/Hearing Impairment</p> <p><input type="checkbox"/> Communication Challenges</p> <p><input type="checkbox"/> Other –specify:</p>	<p>Social Withdraw</p> <p><input type="checkbox"/> Lack of Peer Friendships</p> <p><input type="checkbox"/> Lack of Adult Relationships</p> <p><input type="checkbox"/> Vulnerability/At risk behaviour</p> <p><input type="checkbox"/> Social Isolation</p> <p><input type="checkbox"/> Social Communication Challenges</p> <p><input type="checkbox"/> Additional Information:</p> <p>Family Issues/Concerns/Dynamics</p> <p><input type="checkbox"/> Lack of Family Support to Provide Care</p> <p><input type="checkbox"/> Inability to Meet the Needs of the Child</p> <p><input type="checkbox"/> Family Conflict/Distress</p> <p><input type="checkbox"/> Parent/Child Conflict</p> <p><input type="checkbox"/> Family Break-up</p> <p><input type="checkbox"/> Inconsistent Parenting</p> <p><input type="checkbox"/> Substance Abuse</p> <p><input type="checkbox"/> Physical or Mental Health Issues</p> <p><input type="checkbox"/> Other; Specify: _____</p>

SERVICE HISTORY: (Select all those that apply. Please provide outcome of services in the summary)

Agency	Program	Current	Past	Date	Completed
Addiction Services	David Smith Centre	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
	Rideauwood	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
	Maison Fraternité	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
	Sandy Hill	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
	Others (specify):				
Children's Aid Society	Group Care	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
	Foster Care	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
	Parent Model Home	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
	Collaborative Group Care	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
	Adoption	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
	Kin	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
	Day Treatment	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
	Others (specify):				
Children's Hospital of Eastern Ontario	Psychiatric/Inpatient	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
	Outpatient	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
	Day Treatment	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
	Others (specify):				
Crossroads Children's Mental Health Centre	Camp	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
	Intensive Services	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
	Home Based	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
	Under 6 Program	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
	Day Treatment	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
	Others (specify):				
Roberts/Smart Centre	Crisis	N/A	<input type="checkbox"/>		<input type="checkbox"/>
	Secure	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
	Residential (CFI)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
	YOA	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
	Day Treatment	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
	Others (specify):				
Royal Ottawa Health Care Group	Outpatient Services	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
	Inpatient Services	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
	Day Treatment	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
	YPHU	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
	Others (specify):				
Youth Services Bureau	Young Offender Services	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
	Counselling	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
	Intensive Services (MST/SFI)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
	Community Program	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
	Mobile Crisis	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
	Wraparound	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
	Day Treatment	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
	Residential Crisis Unit	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
	SFI (Parenting Group)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
	Others (specify):				

SERVICE HISTORY: (Select all those that apply. Please provide outcome of services in the summary)

Agency	Program	Current	Past	Date	Completed
Centre psychosocial	Intensive Services	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
	Day Treatment	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
	Mental Health	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
	Others (specify):				
Identify student services or professional support services accessed within the school setting:		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Others (specify):		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>

SUMMARY:

Please provide a summary of the child/youth/family being presented. *Note that the summary will act as your presentation to committee.*

A complete summary should also include the following:

1. Interventions that have been attempted & Outcomes.

2. Request being made to Coordinated Access.

For a financial request, please explain (*current service information, family support/intervention, financial and resource availability, previous funding requests, desired outcomes, goals, phasing out plan, etc.*).

Please note the following information for respite services, camp or organized activities.

<i>Camps, Organized Activities, information required</i>	<i>Respite Services, information required</i>
<ul style="list-style-type: none"> ✓ Camp name, dates and cost. ✓ Note that funds are payable to camps, organizations or service providers. ✓ Cheques are not mailed to camps or organizations. The funds will be held at the Youth Services Bureau. ✓ Coordinated Access requires the original receipt following payment. ✓ Cheques are processed within 5-10 working days. 	<ul style="list-style-type: none"> ✓ A quote from the respite provider must include dates, length, commencement date & rates. ✓ Direct payment is made to organizations or agencies only. ✓ If the family wishes to hire a private respite worker, the parent/guardian will need to complete an invoice that must be signed by the worker(s). The parent/guardian will then submit the invoice to Coordinated Access for reimbursement. ✓ Invoices may be sent weekly, by-weekly or monthly. ✓ Cheques are processed within 5-10 working days.

(Signature of presenter)

Date

(Signature of parent/guardian)

Date

(Signature of client)

Date