

Application Form Mental Health

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
- Psychological Assessments (if available)
- Social History, Social Work, Plans of Care, Safety Plans (if available)
- IPC CANS (only for Integrated Plan of Care request)
- interRAI and/or GAIN SS and/or BASC (Behavior Assessment System for Children)

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.

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*

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/submitting agency			
Presenters			
Name:	Role:	Telephone:	E-mail:
		() -	
		() -	
		() -	
Requesting:			

Child/Youth & Family Information

Child/youth's name			
Date of birth			Age:
Parent/guardian			
Address			Postal Code:
Telephone	Home	() -	Work () -
	Email		
Parent/guardian			
Address			Postal Code:
Telephone	Home	() -	Work () -
	Email		
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:		

DEMOGRAPHIC INFORMATION

If your Organization or Agency agreed to collect the below demographics, print and include them within your application. If you do not collect the below demographics, you must complete this information.

Demographic information

<p>Sex of Client What sex were you assigned at birth?</p> <p><input type="checkbox"/> Male <input type="checkbox"/> Intersex <input type="checkbox"/> Female <input type="checkbox"/> Prefer not to answer</p> <p>Sexual Orientation of Client What is your sexual orientation?</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>Gender Identity What is your current gender identity:</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>Are you currently attending school: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Prefer not to answer</p> <p>If yes, what school do you attend: _____ Grade: _____</p> <p>School Board:</p> <p><input type="checkbox"/> Conseil des écoles catholiques du Centre-Est (CECCE) <input type="checkbox"/> Ottawa Carleton District School Board (OCDSB) <input type="checkbox"/> Conseil des écoles publiques de l'Est de l'Ontario (CEPEO) <input type="checkbox"/> Ottawa Catholic School Board (OCSB) <input type="checkbox"/> Private School <input type="checkbox"/> Post-secondary <input type="checkbox"/> Home schooled</p> <p>Do you know how many school credits you have? <input type="checkbox"/> No <input type="checkbox"/> Yes: #</p>	

Demographic information

Current living situation

Who are you currently living with?

- With parent(s) or guardian(s)
- With sibling(s), no parent(s)/guardian(s)
- Other relative(s)
- Foster family
- Group home
- Friends
- Independent
- Other (please specify) _____
- Prefer not to answer

Client Legal Guardianship

Who is client's legal guardian?

- Both parents Mother only Father only
- Neither parent but other relative(s) or non-relative(s)
- Parental-CAS (Temporary Care Agreement)
 - Specify Who: _____
- Children's Aid Society - Crown Ward
- Children's Aid Society - Society or Temporary Ward
- Children's Aid Society - Interim Care and custody
- Public Guardian Independent - Youth responsible for self
- Other – Specify: _____

Copy of legal guardianship obtained?

- Yes No N/A
- No but declaration/guardianship form signed

Language

What is your mother tongue?

- English French Other

In which language, would you like to receive service?

- English
- French
- Other (please specify) : _____

If discrepancy between mother tongue, child/youth's educational language and preferred language of service, please explain:

- Perception that quality of service is different
- Perception that wait times are different
- Uni-lingual family member
- Other (please specify): _____

Are you comfortable speaking with your care provider in English or French?

- Yes No
- No, but have resources / supports to provide interpretation

Are you comfortable receiving written information in English or French?

- Yes No
- No, but have resources / supports to provide Interpretation

Legal status in Canada:

- Citizen Temporary resident
 - Dual citizen Permanent resident
 - Refugee Prefer not to answer
- What year did you arrive in Canada: _____
- Prefer not to answer

Language

What language(s) is spoken at home?

Child/youth

- English
- French
- Arabic
- Cantonese
- Chinese, n.o.s.
- German
- Indigenous Language
- Mandarin
- Persian (Farsi)
- Portuguese
- Somali
- Spanish
- Italian
- Prefer not to answer
- Other: _____

Caregiver 1

- English
- French
- Arabic
- Cantonese
- Chinese, n.o.s.
- German
- Indigenous Language
- Mandarin
- Persian (Farsi)
- Portuguese
- Somali
- Spanish
- Italian
- Prefer not to answer
- Other: _____

Caregiver 2

- English
- French
- Arabic
- Cantonese
- Chinese, n.o.s.
- German
- Indigenous Language
- Mandarin
- Persian (Farsi)
- Portuguese
- Somali
- Spanish
- Italian
- Prefer not to answer
- Other: _____

Accessibility

Do you identify as a person with one or more disabilities?

- Yes No Prefer not to answer

If yes, check all that apply:

- Seeing Hearing Mobility
- Flexibility Dexterity Pain
- Learning Memory Developmental
- Drug or alcohol dependence Mental/ psychological
- None of the above (please specify): _____

Place of Origin

Where were you born:

- Canada
 - Born outside of Canada
- Specify country: _____

Demographic information

Which race do you identify with (choose all that apply):

- Arab
- Chinese
- White
- Korean
- Indigenous
- West Asian (e.g. Iranian, Afghan, etc.)
- South Asian (e.g. East Indian, Pakistani, Sri Lankan etc.)
- Southeast Asian (e.g. Vietnamese, Cambodian, Thai, etc.)
- Other – specify: _____
- Prefer not to answer

- Black
- Filipino
- Japanese
- Latin American

Indigenous Population

Please indicate which cultural group best represents your identity, or portion of your identity:

- First Nations – Community:
 - Cree
 - Mi'kmaq
 - Other (please specify): _____
- Mohawk
- Ojibway
- Algonquin
- Métis – Community: _____
- Inuit – Region/Community: _____
- Other (please specify): _____
- Prefer not to answer
- N/A

Ethnicity

Which ethnic/ cultural group do you identify with (check all that apply):

- North American (Canadian, American, Mexican)
- Indigenous
- British Isles (English, Irish, Scottish, Welsh)
- French (Acadian, French)
- Other European (Jewish)
- Western European (Austrian, Belgian, Dutch, German, Swiss)
- Northern European (Danish, Finnish, Icelandic, Norwegian, Swedish)
- Eastern European (Czech, Hungarian, Latvian, Lithuanian, Polish, Romanian, Russian, Slovak, Ukrainian)
- Southern European (Bulgarian, Croatian, Greek, Italian, Portuguese, Serbian, Slovenian, Spanish)
- Caribbean (Barbadian, Guyanese, Haitian, Indo-Caribbean, Jamaican, Trinidadian/Tobagonian, West Indian)
- Latin, Central South American origins (Colombian, Mexican, Peruvian, Salvadorian)
- African (Black, Burundian, Congolese, Eritrean, Ethiopian, Ghanaian, Nigerian, Rwandan, Somali, South African)
- West Asian (Afghan, Armenian, Iranian, Israeli, Turk)
- South Asian (Bangladeshi, East Indian, Pakistani, Punjabi, Sri Lankan, Tamil)
- East/Southeast Asian (Cambodian, Chinese, Filipino, Japanese, Korean, Vietnamese)

Family Income

What was your total family income last year?

- \$0 to \$29,999
- \$30,000 to \$59,999
- \$60,000 to \$89,999
- \$90,000 to \$119,999
- \$120,000 to \$149,999
- \$150,000 or more
- Prefer not to answer
- Do not know

How many people does this income support?

What is your source of income?

- Working full time
- Working part time or casual
- Working poor
- Ontario Disability Benefits (ODSP)
- Ontario Works – social support
- OSAP
- Employment Insurance (EI)
- Seasonal or contract
- WSIB – social support
- Other: _____
- Prefer not to answer
- Do not know

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"/>
	Rideau Wood	<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 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 as well 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 send 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