

Children and Youth Services *Referral Form*

DATE REFERRAL SENT		Is youth at risk of harm to self or others: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Phone # of Referent		Fax # of Referent	

a) CLIENT PROFILE (Child/Youth)

Health Card # (if known)	
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Name of Child/Youth	<i>Include full name and any other names used (only if applicable)</i>			
D.O.B. m/d/y		Gender		Preferred Language <input type="checkbox"/> French <input type="checkbox"/> English
Name of Parent/Legal Guardian <i>Residing with child/youth</i>				Relationship
Address				
Preferred Contact Method	<input type="checkbox"/> Phone:	<input type="checkbox"/> E-mail:	<input type="checkbox"/> Other:	
Current School/Day Care <i>Only if applicable</i>				Grade
Custody Type <i>Only if applicable</i>	<i>Are the parents separated?</i> <input type="checkbox"/> No <input type="checkbox"/> Yes	<i>If yes, what is the custody arrangement?</i> <input type="checkbox"/> Joint <input type="checkbox"/> Undetermined <input type="checkbox"/> Sole <i>Specify:</i>		
Current Child Protection Involvement	<i>Are CP services involved?</i> <input type="checkbox"/> No <input type="checkbox"/> Yes	<i>If yes, which agency?</i> <input type="checkbox"/> CAS <input type="checkbox"/> Dilico <input type="checkbox"/> Other	<i>If yes, is the child/youth in care?</i> <input type="checkbox"/> No <input type="checkbox"/> Yes	

Are there any pending court issues e.g. Custody, Separation, Divorce or other? : No Yes

b) THIRD PARTY REFERRAL INFORMATION *Complete only if applicable*

Name of Referent		Title/Agency of Referent	
Phone #			
Relationship to Child/Youth	<input type="checkbox"/> Parent/Caregiver <input type="checkbox"/> School <input type="checkbox"/> Physician <input type="checkbox"/> Other:		
Referral Method	<input type="checkbox"/> In Person <input type="checkbox"/> Phone <input type="checkbox"/> Letter/Fax/E-mail (<i>attach</i>) <input type="checkbox"/> Access Network	Referred Client has provided Verbal Consent to Referent	<input type="checkbox"/> No <input type="checkbox"/> Yes <i>Consent is required</i>
Reason for Referral	<i>Provide a brief summary of the presenting issues:</i>		

FAX TO NOSP OFFICE: **Geraldton/Longlac: 807-854-0006 Nipigon/Red Rock: 807-887-2764**
Schreiber/Terrace Bay: 807-824-1121 Marathon: 807-229-3040 Manitouwadge: 807-826-3088