

Referral Information

Referral Information			
Date of referral:		Information gathered by (check one):	<input type="checkbox"/> Phone <input type="checkbox"/> In person
Agency completing referral:		Name of staff completing referral:	

Family and Child/Youth Information			
Family		Child/Youth	
Contact by: <input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Other _____		First and Last Name:	
Name of Parent(s) or Legal Guardian(s):		DOB:	OHIP #:
Address of Parent or Legal Guardian:		Address of Child /Youth if different than Parent or Legal Guardian	
City/Town:	Main contact #: ()	City/Town:	Main contact #: ()
Postal Code:	E-Mail:	Postal Code:	E-Mail:
Primary language spoken at home:	Translator required: <input type="checkbox"/> Yes <input type="checkbox"/> No	Gender (optional):	# of people living in house:
Does the Child/Youth identify as: First Nations/Métis/Inuit <input type="checkbox"/> Francophone <input type="checkbox"/>			

Please list some strengths of the family and the child/youth	CSP Coordinator Preference
Family:	Please identify the Agency(ies) the family would prefer to be coordinating services (check all that apply) Children's Centre Thunder Bay <input type="checkbox"/> Dilico Anishinabek Family Care – Mental Health and Addictions <input type="checkbox"/> George Jeffrey Children's Centre <input type="checkbox"/> North of Superior Counselling Programs (rural) <input type="checkbox"/> North West Local Health Integration Network (LHIN) <input type="checkbox"/> Child & Community Resources (ASD) <input type="checkbox"/> OPTIONS northwest <input type="checkbox"/> Other: _____ <input type="checkbox"/>
Child/Youth:	

Service Involvement

Child or Youth's Name:	Date of Birth

Relevant Organizations	Active Services	Waitlisted Services
Children's Centre Thunder Bay	<input type="checkbox"/>	<input type="checkbox"/>
Dilico Anishinabek Family Care (please check all that apply) <input type="checkbox"/> Mental Health and Addictions <input type="checkbox"/> Health Team <input type="checkbox"/> Child Welfare	<input type="checkbox"/>	<input type="checkbox"/>
George Jeffrey Children's Centre	<input type="checkbox"/>	<input type="checkbox"/>
North of Superior Counselling Program (NOSP)	<input type="checkbox"/>	<input type="checkbox"/>
North West Local Health Integration Network (LHINS)	<input type="checkbox"/>	<input type="checkbox"/>
Child and Community Resources (CCR) Does the family have a Family Support Coordinator? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>
OPTIONS northwest	<input type="checkbox"/>	<input type="checkbox"/>
Communities Together for Children	<input type="checkbox"/>	<input type="checkbox"/>
Wesway	<input type="checkbox"/>	<input type="checkbox"/>
The District of Thunder Bay Social Services Administration Board	<input type="checkbox"/>	<input type="checkbox"/>
Children's Aid Society of the District of Thunder Bay	<input type="checkbox"/>	<input type="checkbox"/>
Child Development Services	<input type="checkbox"/>	<input type="checkbox"/>
Thunder Bay Regional Health Science Centre	<input type="checkbox"/>	<input type="checkbox"/>
Thunder Bay District Health Unit	<input type="checkbox"/>	<input type="checkbox"/>
Norwest Community Health Center	<input type="checkbox"/>	<input type="checkbox"/>
St. Joes Care Group	<input type="checkbox"/>	<input type="checkbox"/>
Kairos Community Resource Centre	<input type="checkbox"/>	<input type="checkbox"/>
Sister Margret Smith Centre	<input type="checkbox"/>	<input type="checkbox"/>
Brain Injury Services of Northwestern Ontario	<input type="checkbox"/>	<input type="checkbox"/>
Developmental Services Ontario	<input type="checkbox"/>	<input type="checkbox"/>
Canadian National Institute for the Blind (CNIB)	<input type="checkbox"/>	<input type="checkbox"/>
Relevant Specialists (Please list any)	Active Services	Waitlisted Services
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
Any other relevant Organizations not listed above (Please list any)	Active Services	Waitlisted Services
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
School and Board	Individualized Education Plan (IEP)	
	<input type="checkbox"/>	

Screening Tool

Child/Youth Name:		Date of Birth:	
Date Screening Occurred		Name Staff Completing Screening:	
Organization of Staff Completing Screening:		Contact # of Staff Completing Screening:	

Criteria	Description	Weighting	Score
Child/Youth Needs	The child/youth experiences challenges related to multiple areas of development (1 point per impairment – up to 3).	0 to 3	
	The child/youth is accessing multiple specialized services from multiple agencies (1 point per service – up to 3).	0 to 3	
	The child/youth is likely to require ongoing intensive service coordination	0 or 1	
	The child/youth is likely to have ongoing services needs requiring the use of specialized technology or equipment	0 or 1	
	The child/youth requires intensive 1:1 service in more than one environment	0 or 1	
	The child/youth is involved with more than one specialist (besides family physician)	0 or 1	
Family Needs	The family requires assistance to coordinate services	0 or 1	
	The family is caring for another individual (child or otherwise) with complex needs	0 or 1	
	The family is involved with child welfare	0 or 1	
	The family requires assistance in seeking a diagnosis	0 or 1	
External Factors/Environmental Components	The family is experiencing external environmental barriers that are making it difficult to coordinate services (1 point per external barrier – up to 3)	0 to 3	
Scoring	Score of 0 - 5 represents <u>Tier 1</u> ; Score of 6-10 represents <u>Tier 2</u> ; Score of 11-17 represents <u>Tier 3</u> <i>*Information about the Tiers can be found on the Information for Service Providers Document*</i>	Total Score	

Please include any additional information you feel is relevant:

See back for instructions on how to complete screening tool

Criteria	Description	Guidelines
Child/Youth Needs	The child/youth experiences challenges related to multiple areas of development (1 point per challenge – up to 3).	Physical, communication, intellectual, emotional, social and/or behavioural, mental health
	The child/youth requires multiple specialized services from multiple agencies (1 point per service – up to 3).	These may include, but are not limited to: CCTB, NOSP, GJCC, OPTIONS, LHIN, CCR, Dilico, Wesway, Communities Together for Children, DSSAB (SSAH, ACSD), CAS, BISNO, CDS, Canadian Hearing Society, CNIB In addition to specialized services (i.e. IEP, IPRC) with a school board: CSPGNO, CSDCAB, LDSB, Superior Greenstone District School Board, Superior North Catholic District School Board, TBCDSB
	The child/youth is likely to require ongoing intensive service coordination.	Yes (1) or No (0)
	The child/youth is likely to have ongoing services needs requiring the use of specialized technology or equipment	I.e. wheelchair, Augmentative Communication Program, medical technology (G-Tube, respirator, oxygen, insulin pump, etc.)
	The child/youth requires intensive 1:1 service in more than one environment	Yes (1) or No (0) - Does the child/youth require intensive 1-on-1 support in more than one environment
	The child/youth is involved with more than one specialist (besides family physician)	Pediatrician, geneticist, respirologist, endocrinologist, cardiologist, psychology, neurologist, psychiatry, developmental, etc.
Family Needs	The family requires assistance to coordinate services	Yes (1) or No (0) – From the family's perspective
	The family is caring for another individual (child or otherwise) with complex needs	The family is caring for another individual such as a family member or child that requires specialized services (see above)
	Family is involved with child welfare	This could include Family Services, Children and Residential Services, Foster Care, Kinship
	The family requires assistance in seeking a diagnosis	Example: Family interested in assistance in connecting with appropriate professionals and/or services to explore the possibility of a diagnosis, i.e. Developmental pediatrician, psychologist, psychiatry, geneticist, etc.
External Factors/Environmental Components	The family is experiencing external environmental barriers that are making it difficult to coordinate services (1 point per external barrier – up to 3)	Income/social status, employment/working conditions, personal health practices, coping skills, health services, social support networks, social environments, health child development, gender norms, education and literacy, physical environment, biology and genetic endowment, culture, location, language barriers, mental health/addictions, marginalized community, single parent, kinship
Any additional information you feel is relevant: This could include any information that you feel is relevant to the CSP process (i.e. amount of children who live in the house and also require supportive services, significant barriers the families may be experiencing, past history with services, significant allergies, dual diagnosis, complexity of needs, etc). Information provided may also help clarify eligibility for CSP services.		

Consent for Referral

Child or Youth's Name:	Date of Birth

Consent for Coordinating Agency

- ☐ I understand that consent is being obtained for a referral to Coordinated Service Planning (CSP), which has been discussed and explained to me, and/or can be found on the CSP Website (www.childrenscentre.ca/CSP).
- ☐ I understand that the Coordinating Agency for CSP within the District of Thunder Bay is Children's Centre Thunder Bay (CCTB), and as such my and/or my child's personal health information will be shared with CCTB as it relates to CSP.
- ☐ I understand that CCTB uses a secure electronic charting system and that an electronic file of my, and/ or my child's personal health information will be created as it relates to CSP.
- ☐ I give permission for CCTB to contact me regarding CSP after receipt of this consent should they require any more information.
- ☐ I understand that non-identifying information about my participation in CSP will be shared with the ministry for statistical related purposes.

Consent for Provider Organizations

I understand that there are a number of Provider Organizations associated with CSP. I consent to CCTB providing my and/or my child's personal information as it relates to CSP to the following Provider Organizations as required:

- ☐ Children's Centre Thunder Bay
- ☐ Dilico Anishinabek Family Care – Mental Health and Addictions
- ☐ George Jeffrey Children's Centre
- ☐ North of Superior Counselling Programs (rural)
- ☐ North West Local Health Integration Network (LHIN)
- ☐ Child & Community Resources
- ☐ OPTIONS northwest
- ☒ Other: _____

Is the parent/legal guardian required to provide consent? ☐ No ☐ Yes (fill out below)

☐ I confirm that I have the legal authority to provide consent, and if this is a shared or joint custody situation I confirm that I will inform the other guardian of the CSP referral.

_____ Guardian Name	_____ Signature	_____ Witness	_____ Date
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Is the child/youth required to provide consent? ☐ No ☐ Yes (fill out below)

_____ Child/Youth Name	_____ Signature	_____ Witness	_____ Date
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Was this consent completed over the phone? ☐ No ☐ Yes

_____ Name of Staff	_____ Signature of Staff	_____ Date
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