Day Treatment Program Referral Form

Pre-Referral & Consent

Completing a pre-referral consultation is not mandatory, though highly encouraged prior to completing and submitting a Day Treatment Referral. Pre-referral consultations can be requested by emailing intake@wellkin.ca.

- ☐ Pre-referral consultation completed
- ☐ Caregiver consent obtained
- ☐ Youth consent obtained

Child/Youth Information

Name:

Date of Birth: Age:

Address: City: Postal Code:

Telephone: Email:

Gender:

- ☐ Female
- ☐ Male
- ☐ Another Gender Identity

Parent/Guardian Information

Name: Relationship:

Address (if different): City: Postal Code:

Custodial Parent ☐ Yes ☐ No

Telephone: Consent to leave Voicemail: ☐ Yes ☐ No

Email: Consent to Email: ☐ Yes ☐ No

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Referring School Information	
School Name:	Telephone:
Address:	
Grade:	
Principal:	
Contact Person (Name, Phone, Email):	

Reason for Referral

Please provide details regarding the child/youth's difficulties and concerns. Please include/comment on academics, attendance, and social/peer relations. Please also include any strategies already implemented in an effort to support the child. *(Please attach an additional word document if there is not enough space provided)*

Considerations of Diversity and Accessibility

☐ Language	☐ Physical Health
☐ Culture	☐ Ethnicity
☐ Religion	☐ Sexual Orientation
☐ Other	

Comments:

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Strengths, Needs, Goals
Referring Service Provider's View of Child/Youth's Strengths (Please include information about their personality, interests, likes, and where they shine): Referring Service Provider's View of Child/Family Needs: Referring Service Provider and Community School's Expected Outcomes/Goals for this Child/Youth:
Perspectives
Child/Youth Perspective - Please describe the child/youth's point of view of the current situation and what the needs are: Caregiver Perspective- Please describe the caregiver/family's point of view of the current situation, what support they believe is required, and what they hope will be achieved:

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Planning Process

If there are any individuals/agencies that are significant in the lives of the child/youth and/or family that should be included in the planning process, please specify below:

Describe the family's intended involvement during the treatment process (i.e., accessing parenting support, attending appointments, participating in therapy, groups, etc.):

School-Based Services

Service	Yes	No	Provider Information (Name, Telephone, Email)	Details (When, Outcomes)
Psychology	☐	☐		
Social Worker/School Support Counsellor	☐	☐		
Behavioural Team	☐	☐		
LST/SPST	☐	☐		
Other:	☐	☐		

Classroom Supports

- ☐ Educational Assistant
- ☐ Behaviour Team/TOSA
- ☐ Technology
- ☐ Universal Supports
- ☐ Modified Day/Schedule
- ☐ Individual Education Plan (IEP)
- ☐ Behaviour Plan
- ☐ Safety Plan
- ☐ Sensory/Environmental Adaptations
- ☐ Identification Placement Review Committee (IPRC) If yes, what type of exceptionality?

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Assessments			
Type	**Date**	**Completed**	**Findings/Diagnosis**
Psychological			
Psychiatric			
Academic			
Speech/Language			
Occupational Therapy			
Other			

Community Services / Diagnoses

Please list all services that the child/youth has accessed in the last 5 years, indicating any services that are currently ongoing:

Service Type	**Service Provider**	**Start Date** (Month, Year)	**End Date** (Month, Year)

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Please list any medical and/or psychiatric diagnoses, identifying both confirmed and suspected diagnoses:

Health History (include any medical incidents):

Please List Current Medications:

Risk Factors

- ☐ Child/youth has run away
- ☐ Past or present substance abuse by any family member
- ☐ Self-harming behaviours or suicidal talk by child/youth
- ☐ Prescence of weapons in the home
- ☐ Past or present gang-related involvement by any family member
- ☐ Child/youth displays behaviour that may pose a safety risk to either themselves or others (i.e., aggression, destruction, etc.)
- ☐ Past or present experiences of neglect for the child/youth
- ☐ Past or present violence among family members
- ☐ Past or present sexual abuse of child/youth
- ☐ Past or present physical abuse of child/youth
- ☐ Past or present fire involvement
- ☐ Past or present sexually intrusive behaviours by the child/youth
- ☐ Hospitalization or emergency room visits related to child/youth behaviour
- ☐ Past or present behaviour considered to be out of control

Details:

Referring Worker Information

Name of Professional: Agency:

Address: Phone:

Email:

Consent Signatures

Parent/Guardian Name:

Signature: