central toronto youth services
NEW OUTLOOK

EMPOWERING YOUTH CHANGING LIVES

NEW OUTLOOK REFERRAL FORM

Contact: 416-924-2100 x437   Fax: 416-924-2930

IMPORTANT: Please ensure the following prior to forwarding the referral:

- ✓ **Client is aware of the referral**
- ✓ **Client Consent Form has been signed and dated**
- ✓ **All supporting documentation should be included with this referral**

Specify Program: Visit **www.ctys.org** for specific program criteria. All programs for ages 15 – 24.

☐ **Community Support and Intervention** ☐ **Day Program** ☐ **Youth Hostel Outreach Program**

Referral Date: (DD/MM/YY) ___________________

Referral Source Information

Name:		Agency:
Address:		
Number/Street	City	Postal Code
Telephone: Ext:		Cellular:
Email:		Fax:
Relationship to young person:		
Signature of referral source:		

Client Information

Last Name:	First Name:	Pronouns:
*Address:		
Number/Street/Apt.	City	Postal Code
*If no fixed address, where does youth frequent?		
Home Telephone:	Cellular:	
Email:	Other:	
Date of Birth (DD/MM/YY):	Age:	
Gender:	Birthplace:	
Cultural Background:	Health Card #:	
Language(s):		
Immigration/Citizenship/Status:		
Other information:		
Education/employment:		
History of homelessness (current or past shelter use, length of time):		
Source of income:		
What supports does this youth currently have?		
Accessibility needs?		

Client Contacts

Psychiatrist:

Address:

Number / Street | City | Postal Code

Telephone:

Frequency of contact:	Length of contact:

Diagnosis:				
		Date:	By:	Tel #:
		Date:	By:	Tel #:
		Date:	By:	Tel #:

Additional Information:

Concurrent Disorder? ☐ Yes ☐ No	Developmental Delay? ☐ Yes ☐ No
Comments:	Comments:

General Practitioner/Primary Care:

Address:

Number/Street | City | Postal Code

Telephone:

Other medical concerns: **(**include **any relevant** past or current conditions, allergies and related medications, treatments, and/or physicians involved)

Current Presenting Issues**: (Within the past 6 months)**

Symptoms (☑ all that apply):

- ☐ Hearing Voices
- ☐ Delusions (firm false beliefs)
- ☐ Agitation/Restlessness
- ☐ Anxiety
- ☐ Paranoia
- ☐ Isolates
- ☐ Depression
- ☐ Self-Harming
- ☐ Talking to themselves
- ☐ Intensified mood swings
- ☐ Sleep Disturbances
- ☐ Ideas of grandeur
- ☐ Homicidal Ideation
- ☐ Suicidal Ideation
- ☐ Trauma history
- ☐ Other__________________
- ☐ Other__________________

Are there any significant events in the youth's life that are important for us to know?

Medications:

Drug Name	Dosage & Frequency	Administered by	Compliance	Prescribed by

History of Psychiatric Admission: Place/Date/Duration	
Problematic substance use:	
☐ Past	☐ Current
How was this addressed?	How is this being addressed?
Safety Concerns:	
☐ Past	☐ Current
How was this addressed?	How is this being addressed?

Lawyer:	
Name:	
Telephone:	Ext:
Provide legal history/pending charges/upcoming court dates:	

Emergency Contact Information		
Name:	Relationship:	
Address:		
Number/Street/Apt.	City	Postal Code
Home Telephone:	Cellular:	Other:
Email:		
Additional Information:		

*Please attach any relevant assessments, summaries or documents which may support this referral

Office Use Only			**Follow-up**
Client ID number:	Date Received:	Date Scanned:	Day Program: Site visit date: ___________________________ Intake meeting: date __________________________________

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FAX TRANSMISSION

TO:	**TYPE RECIPIENT NAME**	DATE:	**2/13/2020 1:05 PM**
FAX No.:	**TYPE RECIPIENT FAX NUMBER**	SUBJECT:	**TYPE FAX SUBJECT**
FROM:	**TYPE YOUR NAME**	PAGES *(Inc. Cover)*:	**TYPE #**

Please ensure that you include the following as part of the New Outlook Referral Package:

- ☐ **Referral Form**
- ☐ **Authorization for Disclosure, Transmittal or Examination of Confidential Information**
- ☐ **Psychiatric/Hospital Discharge Summary reports (mandatory for Day Program)**
- ☐ **Educational reports (mandatory for Day Program)**
- ☐ **Other:**

Any additional information:

CAUTION: This transmission may contain confidential information intended for the specified recipient only.

Transmission, access, use and disclosure of the contents or attachments herein are governed by various Acts of Legislation including: the Youth Criminal Justice Act, the (Ontario) Child and Family Services Act, the Personal Health Information Protection Act and the Freedom of Information and Protection of Privacy Act. If you have received this transmission in error, please notify us immediately by e-mail mail@ctys.org or by telephone (416-924-2100) and delete the original message. Contents of this transmission do not necessarily reflect the official views or policies of Central Toronto Youth Services.

NO Intake Form/April 2018