CTYS central toronto youth services

EMPOWERING YOUTH CHANGING LIVES

New Outlook – Day Program Referral Form

Section A: *Client Information*

Name		Pronoun(s)
D.O.B. (dd/mm/yy):	Health Card #	
Address Number / Street /Apt. City Postal Code		
Referral Source		
Date of Referral	Client consents to service (Day Program ☐ Yes ☐ No	

Section B: *Educational History*

Grades completed **Check ☑ all that apply**

7	8	9	10	11	12

What was the last school you attended?

When did school become challenging?

Always has been	Grades 7-8	Grades 9-10	Grades 11-12	Never has been

Did you have an IEP (Individual Educational Plan)? No ☐ Yes ☐ (Please specify below)

	Learning exceptionalities -
	Academic accommodations -
	Other:

Which of the following factors contributed to your school issues? (please indicate all that apply ✓)

	Anxiety		Peer influences		Self-harm		Asperger's/ASD
	Psychosis		Learning disability		Substance use		Developmental disability
	Bipolar disorder		Bullying/harassment		Use of electronics		Physical disability
	Depression		Sensory sensitivity		Financial		Medical illness
	ADHD/ODD		Emotional sensitivity		Transportation		Day/Night reversal /sleep issues
	Other:						

When you are not attending school, how do you spend your day? (please indicate all that apply ✓)

	Watching TV		Sleeping		Working
	Using electronics – gaming/internet		Stay at home		Reading
	With friends – online		Going into the community		Gym /exercising
	With friends - face to face		Taking care of my parent(s)		Baby-sitting/watching my siblings
	Other:				

What strengths do you have?

Section C: *Reason for Referral* - Outcome of service (☑ all that apply):

- ☐ Opportunity to connect with peers
- ☐ Learn about life skills (ie. budgeting, cooking, etc.)
- ☐ Support around acquiring credits
- ☐ Health & fitness opportunities
- ☐ Learn more about mental health
- ☐ Learn strategies to help me cope better
- ☐ Other:
- ☐ Other:

Are there any aspects of being in this group that you think might feel uncomfortable?

What would make you feel welcome or more comfortable?

How would you rate your comfort level using TTC (public transit)?
(Please mark on the line what feels most true for you)

Poor ______ Fair ______ Good ______ Excellent

How are you financially supported?

- ☐ ODSP/ OW
- ☐ Employment
- ☐ Family
- ☐ Other

Section D: *Health Information*

Allergies/Sensitivities *(include any dietary requirements)*:

Epinephrine ("Epi Pen") required? Yes ☐ No ☐

How would you rate your general health: *(Please mark on the line what feels most true for you)*

Poor ______ Fair ______ Good ______ Excellent

Medical information *(include heart/respiratory conditions, seizure disorders or other conditions we should know about)*:

Do you have accessibility needs? (i.e. assistive devices, hearing-aids, etc.)

Section E: *Caregiver/Family/Case Management & Other Community Supports*

Current living situation

	Living with parent(s)/caregiver		Supportive housing		Independently		Other:
	Foster care		Group Home		Residential treatment		

Primary contact		
1. Last Name:	First Name:	
Relationship:	Pronoun(s)	
Address: Number / Street /Apt. City Postal Code		
Home Telephone:	Cellular:	
Email:	Other:	
Cultural Background:	Language(s):	Interpreter required ☐ Yes ☐ No
Other information:		

Case Manager Information & Other Community Supports	
Name:	
Agency	Preferred pronoun(s)
Work Telephone:	Cellular:
Email:	Other:
Frequency of contact:	
Who are your other supports in the community (i.e. psychiatrist, counsellor, therapist, etc.)	

Please note: *For the purpose of intake, the New Outlook Day Program requires supporting documentation around mental health diagnosis (Discharge Report/ Summary, Letter from a doctor) and learning needs (IEP, Credit Counselling Summary, Transcript). Please ensure that client consent to this referral is included*

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