HALTON COORDINATED SERVICE PLANNING
one family. one story. **one plan.**

Coordinated Service Planning, Halton Region
Service Provider Referral Form
(to be completed in partnership with family)

** PLEASE NOTE: The following information MUST be true for the referred child/youth to be eligible for Coordinated Service Planning. Unless the requirements are satisfied, please do not submit this form.

- ❑ Child/Youth resides in Halton Region
- ❑ Child/Youth is between the ages of 0 and 18 - OR - 21 years old and younger and still enrolled in school
- ❑ Child/Youth is currently accessing 2 or more services
- ❑ The family has provided informed consent to submit this application and all associated information on their behalf and to move forward in registering them for service
- ❑ The family is willing to communicate and share information and reports
- ❑ Service providers have had a recent level 1 service coordination meeting with the family and providers involved

Today's Date: __ __ __ __/ __ __/ __ __ (YYYY MM DD)

Service Provider name: _____

Service Provider signature: _____

Child/ Youth Information:

Name: _____ (First) _____ (Last)

Sex: ☐ M ☐ F ☐ Other

Date of Birth: __ __ __ __/ __ __/ __ __ (YYYY MM DD) Age: _____

School: _____

Grade: _____ IEP: ☐Yes ☐ No

Address: _____

Home #: (__ __ __) __ __ __ - __ __ __ __

City: _____

Cell #: (__ __ __) __ __ __ - __ __ __ __

Postal Code: __ __ __ __ __ __

Language: ☐ English ☐ French ☐ ASL

☐ Other; specify: _____

Diagnosis: _____

Does the child/youth have diagnosed or suspected Fetal Alcohol Spectrum Disorder (FASD)

- ❑ **Diagnosis**
- ❑ **Suspected**
- ❑ **unknown**

Parent/Guardian Information:

Parent/Guardian #1

Name: _____

Relation to child: _____

Date of Birth: __ __ __ __/ __ __/ __ __ (YYYY MM DD)

Address: _____

Parent/Guardian #2

Name: _____

Relation to child: _____

Date of Birth: __ __ __ __/ __ __/ __ __ (YYYY MM DD)

Address: _____

City: _____

Postal Code: __ __ __ __ __ __

Phone: (H)_____ ❑ Message okay?

(B)_____ ❑ Message okay?

(C)_____ ❑ Message okay?

Email Address: _____

City: _____

Postal Code: __ __ __ __ __ __

Phone: (H)_____ ❑ Message okay?

(B)_____ ❑ Message okay?

(C)_____ ❑ Message okay?

Email Address: _____

Referral Source Information:

Name: _____ _____
First Last

Address: _____

City: _____

Postal Code: __ __ __ __ __ __

Tel #: (__ __ __) __ __ __ - __ __ __ __

Source:
- ☐ Parent/Guardian
- ☐ Medical Agency
- ☐ Community Agency
- ☐ School
- ☐ Other; specify: _____

Name of agency (if applicable) _____

Current Services:

Please list the services the child/ youth is **currently** accessing:

	Service	Service Provider	Duration
1			
2			
3			
4			
5			

Part of the intake process is a phone screening tool that helps us to determine whether CSP is a good fit to match the family's needs. The screen can be done with referring service providers, caregivers or youth directly. If you have a strong understanding of the family/child/youth that you are referring, it is suggested that you complete the phone screen with our intake department. If you do not feel that you have enough information about the family/child/youth, then please indicate that you would like intake to connect directly with the family.

- ❑ Please contact **me** directly to conduct the screen
- ❑ Please contact the **caregiver** to conduct the screen (you must notify the family that we will be calling)
- ❑ Please contact the **youth** to conduct the screen (you must notify the youth that we will be calling)

Fax to (905) 681-7477