

Transitional Aged Youth (TAY) Initiative Youth-Centered Systems Integration

REFERRAL FORM

Today's date:	Youth initials:	Gender:
	Youth age (years):	Location:

AGENCY INFORMATION

Youth referring agency:		
Referring worker:		
Phone number:	Fax number:	Email address:

CLIENT INFORMATION

Highest grade level completed:	Is youth presently in school? YES NO
Last school attended:	School contact person:
Identify specialized education program (if applicable)	
Are you currently employed?	Employment Position:
Length of employment:	
Current living situation:	
Relevant physical health history:	
Family physician:	
Current diagnosis:	
Current relevant medication(s):	

Who prescribed?

Is substance use an area of concern?	YES	NO	Current use of substances?	YES	NO
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Client's area(s) of interest (i.e. recreation, arts, sports, culture):

Summary of contact: Date first seen:

Date last seen:

Summary of involvement:

Approximate number of meetings:

Please list types of assessments completed and corresponding dates

Date:

Type of Assessment:

Client's strengths:

Client formal and informal supports:

Presenting issues:

Treatment goals:

RISKS (potential harm to self, risk behaviours):

Previous service involvement and youth response to service:

IDENTIFIED SERVICE NEEDS

Case management	Supportive housing	Counselling	Education
Medical/physical health	Employment	Recreation	Family relations

Other information:

oneLink referral made? YES NO If yes, date referral made:

Client consent obtained to share information? YES NO