

## 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):

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**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:

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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

## CLIENT CONSENT

I \_\_\_\_\_ dob: \_\_\_\_\_ understand that the **Transitional Aged Youth Coordinating Committee** will be meeting to discuss the coordination of services for myself.

The purpose of this meeting is to provide an opportunity to determine services, directions and strategies to assist with providing seamless delivery system for young people ages 16 to 24. The emphasis of these meetings is on providing a client centred approach to reduce barriers, offer an effective transition from youth to adult services and to build on current and new partnerships to assist in supporting young people in the areas of mental health and addictions.

This consultation process will necessitate the sharing of information among members\* of the Transitional Aged Youth Coordinating Committee. This process may also involve the gathering and sharing of information from other services who may be invited to this consultation.

### **Other agencies** \_\_\_\_\_

*Specify other Agencies to be involved*

It is understood that I/We will receive a copy of any recommendations arising from this consultation and further authorize that the Transitional Aged Youth Coordinating Committee to release recommendations arising.

I/We understand that this consent will remain in effect for three (3) months following the date of signature, or sooner should I/We withdraw consent. This consent will only be used for the process described above. I/We hereby give permission to the sharing of information as described above.

### **Permission to forward Transitional Aged Youth Coordinating Committee information electronically:**

Yes

No

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

WITNESS: \_\_\_\_\_

- Associated Youth Services of Peel
- Centre for Addictions and Mental Health
- Canadian Mental Health Association- Halton & Peel
- Community Care Access Centre
- The Credit Valley Hospital and Trillium Health Centre
- Peel Addiction Assessment and Referral Centre
- Peel Children's Centre
- Peel District School Board
- Peel Youth Village
- Support House
- Supportive Housing in Peel
- Mississauga YMCA Employment Resource Centre
- Developmental Services of Ontario
- Youth Justice – MCYS
- Peel Crisis Capacity Network – PCCN
- Peel Regional Police Services