Support House

Transitional Aged Youth (TAY) Initiative

Youth-Centered Systems Integration

REFERRAL FORM

Today's date: 17-Aug-2023	Youth initials:	Gender:
	Youth age (years):	Location:

I give permission for TAY committee members to connect with me via the selected method(s) below for the purpose of relaying meeting information and coordination as well as post-meeting follow up:

☐ Phone number: ☐ Email address:

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 ○

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 assesments 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 ◯ *Personal Health Information Protection Act, 2004*

TRANSITIONAL AGED YOUTH COORDINATING COMMITTEE
YOUTH-CENTRED SYSTEMS INTEGRATION

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**
- **ADAPT (Halton Alcohol, Drug & Gambling Assessment, Prevention & Treatment Services)**
- **Bridging the Gap**
- **Canadian Mental Health Association-Halton**
- **Community Youth Programs**
- **Connections Halton**
- **Halton Healthcare**
- **Halton Support Services**
- **Hope Place Centres**
- **R.O.C.K. (Reach Out Centre for Kids)**
- **Stride**
- **Summit Housing & Outreach Programs**
- **Support House**

SUBMIT FORM