Children's Treatment Network
Réseau de traitement des enfants

Request for Local Team Services Only

Fax to CTN ACCESS Intake at (705) 792-2775

Date of Referral: _____ (dd-mmm-yyyy) **Shared Client Record ID Number**: _____

CLIENT INFORMATION This child/youth is a CTN client, demographics and caregiver information is accurate in GoldCare ☐ Yes ☐ No (complete fields)		
Name: (SURNAME) (FIRST)	DOB (dd-mmm-yyyy)	Gender: M☐ F☐ O☐
Address:		
School:	Grade:	
School Board: ☐ N/A ☐ YCDSB ☐ YRDSB ☐ SCDSB ☐ SMCDSB ☐ CSDCCS ☐ CSViamonde ☐ OTHER		
Diagnosis:	Physician:	GMFCS:

CAREGIVER #1 Address same as client ☐YES ☐NO (complete fields)		**CAREGIVER #2** Address same as client ☐YES ☐NO (complete fields)	
Relationship to Client:	Custody:	Relationship to Client:	Custody:
Name:		Name:	
Address:		Address:	
Primary #:	Alternate #:	Primary #:	Alternate #:
Email:		Email:	
Language(s) Spoken:	Interpreter: YES ☐ NO ☐	Language(s) Spoken:	Interpreter: YES ☐ NO ☐
French Language Services Required? YES ☐ NO ☐		French Language Services Required? YES ☐ NO ☐	

SERVICE	**(✓)**	**Describe Reason for Referral or areas(s) of need**
Audiology		
Brief Resource Service (BRS)		
Child and Family Counseling (C&FC)		
Family Mentor Program		
Feeding (Local Team Level)		
Growth and Development Clinic (G&D)		
Occupational Therapy (OT)		
Physiotherapy (PT)		
Military Service Navigation		
Service Navigation (SN)		
Service Coordination		

Provide Relevant Information/Client Status (attach relevant report/test results) Degenerative Condition? YES ☐ NO ☐

_____

List services/agencies currently involved with Child and Family:

_____

Youth/Family agrees with this Referral including the collection and sharing of information for the purposes of processing Referral. ☐Yes ☐ No

Network Consent for Sharing of Information among Child and Family Team members has been discussed and completed with Youth/Family. ☐Yes ☐No

(If "YES", who provided the consent?) ☐Client/Youth ☐Parent/Guardian ☐CAS

Youth/Family agrees to CTN's use of the email address for the purpose of communicating with the family about upcoming Network events and Educational opportunities. ☐Yes ☐ No

_____ _____ _____

Signature of Referring Person *Print name & Professional Designation* *Date (dd-mmm-yyyy)*

_____ _____ _____

Name of Referring Agency *Email Address* *Telephone Number*