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 all fields					
Name:		**DOB:**		**Gender:**	☐M ☐F ☐O
(Surname)	(First Name)	(dd-mmm-yyyy)			
Address:					
(Street Address, Include Apt/Unit Number)	(City)	(Province)	(Postal Code)		
School:		**Grade:**			
School Board: ☐N/A ☐SCDSB ☐SMCDSB ☐YCDSB ☐YRDSB ☐CSDCCS ☐CSViamonde ☐Other					
Diagnosis:		**Physician:**			

CAREGIVER #1 Address Same As Client: ☐YES or ☐NO, please complete all sections below		**CAREGIVER #2** Address Same As Client: ☐YES or ☐NO, please complete all sections below	
Relationship to Client:		Relationship to Client:	
Custody Status:		Custody Status:	
Name:		Name:	
Address:		Address:	
Primary#:	Alternate#:	Primary#:	Alternate#:
Email Address:		Email Address:	
Languages Spoken:		Languages Spoken:	
Interpreter Required for Language Listed Above ☐ YES ☐ NO French Language Services Required ☐ YES ☐ NO		Interpreter Required for Language Listed Above ☐ YES ☐ NO French Language Services Required ☐ YES ☐ NO	

SERVICE	**(☐)**	**Describe Reasons OR Areas(s) of Need (limit of 800 characters)**
Audiology (York Region only)	☐	
Brief Resource Service (BRS)	☐	
Family Mentor Program	☐	
Feeding (Local Team Level)	☐	
Occupational Therapy (OT)	☐	
Physiotherapy (PT)	☐	
Service Navigation (SN)	☐	
Service Coordination	☐	

Provide relevant information / Client Status (attach any relevant reports and/or 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 the 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 email address for the purpose of communicating with the family about upcoming Network events and Educational Opportunities ☐ YES ☐ NO

(Referring Person's Signature) (Print Name and Professional Designation) (Name of Referring Agency)

(Email Address of Referring Person) Fax Number for Referrer (Must Include) Referrer's Phone Number and Extension

FORM REVISED: June-21-2019