YOUTH TREATMENT CENTRE REFERRAL PACKAGE

Information for Referral Sources

1. The referral package for the Youth Treatment Centre (YTC) includes several documents as outlined below. Please use the check boxes to ensure all documentation is completed and forwarded.

   - ❑ Youth Treatment Centre - Referral Form
   - ❑ Youth Treatment Centre - Caregiver Questionnaire (if applicable)
   - ❑ Youth Medical Assessment
   - ❑ Consent for Release of Personal Health Information
   - ❑ Discharge Summaries from previously attended Treatment Programs, if any
   - ❑ Summary Reports from Mental Health and Addictions Services and/or community professionals

2. Upon completion of the required forms, the referral package can be forwarded via regular mail or facsimile as follows:

Referral Coordinator
Youth Addictions Treatment Centre
Central Health
C/O 50 Union Street
Grand Falls-Windsor, NL
A2A 2E1
PH: (709) 489-6193 / 489-6268
FAX: (709) 489-6810
EMAIL: ytcreferrals@centralhealth.nl.ca

Referral Coordinator
Youth Mental Health Treatment Centre
Eastern Health
C/O 760 Topsail Road
Mount Pearl, NL
A1N 3J5
PH: (709) 752-3914 / 752-4529
FAX: (709) 752-6851
EMAIL: ytcreferrals@easternhealth.ca

3. The Referral Coordinator will review the referral to determine appropriateness and to ensure all documentation is received. The referral application will be forwarded to the Provincial Admissions Committee for final review and approval.

4. Referral sources may be asked to be available via telephone during meetings of the Provincial Admissions Committee to provide additional information.

5. Referral sources will be notified of the decision of the Provincial Admissions Committee and a form letter will be sent to the referral source to confirm acceptance. The referral source will be required to advise the caregiver/guardian and youth of the committee decision.

6. Youth will be assigned to a waitlist if there is no space available in the Treatment Centre. YTC staff will consult with the referral source to assist in identifying appropriate community programs to support the youth and the caregiver/guardian while the youth is on the waitlist. Alternately, if waiting for admission is not clinically advisable, YTC staff will assist with the process of referral to an alternate, out of province treatment centre.

7. For individuals who are requesting admission to the Withdrawal Management program only, please call (709)489-6193 or (709)489-6268 to complete a telephone intake.

Youth's Name: _____ Signature _____ Date: DD/MONTH/YYYY

Eastern Health

Central Health

Mental Health and Addictions

Youth Treatment Centre
REFERRAL FORM

email: ytcreferrals@easternhealth.ca
email: ytcreferrals@centralhealth.nl.ca

Name: _____

HCN/MCP: _____

Date of Birth: DD/MONTH/YYYY

CRMS Number: _____

Date Completed: DD/MONTH/YYYY CRMS #: _____

1. YOUTH INFORMATION					
Current Street Address:					
City:	Province:			Postal Code:	
Telephone:		Telephone:			
Gender:	Language:				
Child Youth & Family Services In-Care/Custody Status:		□ Voluntary	□ Interim	□ Temporary	□ Continuous
Indicate the youth's current residence: □ Two parent household □ Single Parent Household (please indicate: mother / father □ Grandparent(s) □ Group Home □ Foster Home □ Other:		Indicate the youth's permanent residence: □ Same as current residence □ Two parent household □ Single Parent Household (please indicate: mother / father □ Grandparent(s) □ Group Home □ Foster Home □ Other:			
First Nations Identity (if applicable):					
Aboriginal Status (if applicable):					
Band Member (if applicable):					
Band Name (if applicable):					
Status Number (if applicable):					
List any language other than English spoken at home: List any cultural or spiritual needs this youth may have:					

SIGNATURE: _____ **PRINT:** _____ **DATE:** DD/MONTH/YYYY

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Date of Birth: DD/MONTH/YYYY

CRMS Number: _____

2. REASON FOR REFERRAL

What are the major areas to be addressed while at the Youth Treatment Centre?

3. CHALLENGES (which of the following items are challenges for this young person? Check the appropriate boxes and please describe)

Learning Needs:

□ School Attendance	□ Behavior at School	□ Lack of Educational Supports	□ Peer Groups

□ Learning Disability (specify):

□ Other (specify):

Please describe:

Mental Health: Check the appropriate boxes and please describe.

□ Self-Harm	□ Suicidal Ideation	□ Past Suicidal Behavior
□ Anxiety	□ Depression	□ Cognitive Impairment
□ Medication Compliance	□ Emotional Regulation	□ Fetal Alcohol Spectrum Disorder (FASD)
□ Eating Disorder	□ Psychosis	□ Conduct Disorder
□ Attention Deficit Hyperactivity Disorder (ADHD)	□ Oppositional Defiant Disorder	□ Bipolar Disorder
□ Other (specify):	□ Elimination Disorders	

Please describe:

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Trauma: Check the appropriate boxes and please describe.

□ Emotional Abuse □ Physical Abuse □ Sexual Abuse □ Medical Trauma □ Witness to Violence □ Witness / Victim of Criminal Activity □ Post Traumatic Stress Disorder

□ Other (specify):

Please describe:

Social / Behavior / Development Considerations:

□ Violent Behavior
□ Running / Absent Without Permission
□ Autism Spectrum Disorder
□ Aggression
□ Impulsivity
□ Other (specify):
□ Self Esteem
□ Inability to Focus
□ Peer Interaction
□ High Risk Behaviors (including sexual)
□ Social Isolation

Please Describe:

Physical Issues:

□ Visually Impaired □ Hearing Impaired □ Mobility

Please describe:

Does youth require assistance to complete self-care tasks? □ Yes □ No

If yes, please specify:

Addictions / substance abuse / gambling:

Substance	Amount Used	Route of Administration	Frequency of Use	Age first used	Date last used
					DD/MONTH/YYYY
					DD/MONTH/YYYY
					DD/MONTH/YYYY
					DD/MONTH/YYYY
					DD/MONTH/YYYY
					DD/MONTH/YYYY

SIGNATURE: _____ **PRINT:** _____ **DATE:** DD/MONTH/YYYY

Eastern Health acknowledges and respects the privacy of individuals. This personal information is being collected under the authority of Sections 32 and 33 of the *Access to Information and Protection of Privacy Act.* And will be used for processing your request for Mental Health and Addictions Services. Please direct any questions about this collection to: Privacy Officer, Eastern Health, Quality and Risk Management, 12th Floor Southcott Hall, 777-8025.

Central Health takes seriously your right to privacy and our duty to keep your information safe and secure. Please ask to see our privacy brochure for more details on our privacy practices or if you have any questions about privacy and practices at Central Health please contact 709-256-5743 or visit www.centralhealth.nl.ca.

Gambling Type	Frequency	Date last Gambled	Start Age
		DD/MONTH/YYYY	
		DD/MONTH/YYYY	
		DD/MONTH/YYYY	
		DD/MONTH/YYYY	
		DD/MONTH/YYYY	
		DD/MONTH/YYYY	
		DD/MONTH/YYYY	

Comments:

In youth's current residence is there substance abuse and / or gambling issues? □ Yes □ No

Comments:

Does youth use substances and/or gamble with anyone he/she lives with? □ Yes □ No

Comments:

Is youth dependent on alcohol? □ Yes □ No

Is youth dependent on high dose benzodiazepines (greater than 50mg equivalent)? □ Yes □ No

Is youth dependent on opioids? □ Yes □ No

Has youth ever been hospitalized as a result of substance use/abuse? □ Yes □ No

Has youth ever overdosed? □ Yes □ No (if yes, please provide details)

Has youth experienced symptoms such as seizures or hallucinations when stopped using substance(s) in the past? □ Yes □ No

If yes, please provide details on substance used and associated symptoms:

SIGNATURE: _____ **PRINT:** _____ **DATE:** DD/MONTH/YYYY

Is youth requesting admission to a withdrawal management bed? □ Yes □ No
If yes, have attempts been made in the past to abstain from substances or drugs? □ Yes □ No
What were the results?
Is there an option for withdrawal management support in youth's community? □ Yes □ No
Is youth currently prescribed methadone? □ Yes □ No
If yes, please provide details (ie. physician, pharmacy, dosage, etc.):
Does the youth use tobacco products? □ Yes □ No
Does the youth use nicotine replacement therapies? □ Yes □ No
4. IMPACT OF ADDICTION
Please describe how the factors indicated in Section 2 have impacted this young person and their ability to function safely at home, school, and in their community:

5. HEALTH INFORMATION

Physician's Name:	Physician's Telephone Number:
Other attending Health Care Practitioners	Contact Phone Number
Name:	Telephone Number:
Name:	Telephone Number:
Name:	Telephone Number:
Name:	Telephone Number:

SIGNATURE: _____ **PRINT:** _____ **DATE:** DD/MONTH/YYYY

Allergy Information (include all food allergies):	
Type of Allergy	Reaction

Does youth carry an Epi-Pen? □ Yes □ No

List any medication this youth is currently taking (include over the counter, vitamins, and herbals):

Name	Dosage	Name	Dosage

List any special medical needs of this youth:

□ Asthma	□ Diabetes	□ Seizures
□ Brain Injury	□ Dietary	□ Neurological Disorders

□ Other (specify):

Has youth ever been tested for HIV? □ Yes □ No	Has youth ever been tested for Hepatitis C? □ Yes □ No

Comments:

6. CAREGIVER / GUARDIAN INFORMATION **(Complete for all persons involved in parenting this youth)**

Last Name:	First Name:	
Current Street Address: (if different from youth's):		
City:	Province:	Postal Code:
Primary Telephone Number:	Other Telephone Number:	
Occupation:		
Can a message be left at either of these numbers? □ Yes □ No		

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Mental Health and Addictions

Youth Treatment Centre
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Name: _____

HCN/MCP: _____

Date of Birth: DD/MONTH/YYYY

CRMS Number: _____

Relationship to Youth: □ Birth Parent □ Adoptive Parent □ Step-Parent □ Grandparent □ Foster Parent □ Other:		Marital Status: □ Single □ Divorced □ Married □ Widowed □ Common Law □ Separated	
Last Name:	First Name:		
Current Street Address: (if different from youth's):			
City:	Province:		Postal Code:
Primary Telephone Number:	Other Telephone Number:		
Occupation:			
Can a message be left at either of these numbers? Yes □ No			
Relationship to Youth: □ Birth Parent □ Adoptive Parent □ Step-Parent □ Grandparent □ Foster Parent □ Other:		Marital Status: □ Single □ Divorced □ Married □ Widowed □ Common Law □ Separated	
Last Name:	First Name:		
Current Street Address: (if different from youth's):			
City:	Province:		Postal Code:
Primary Telephone Number:	Other Telephone Number:		
Occupation:			
Can a message be left at either of these numbers? Yes □ No			
Relationship to Youth: □ Birth Parent □ Adoptive Parent □ Step-Parent □ Grandparent □ Foster Parent □ Other:		Marital Status: □ Single □ Divorced □ Married □ Widowed □ Common Law □ Separated	

7. SCHOOL INFORMATION

Is this youth attending school? □ Yes □ No If yes, Name of School:	Grade:	Date last attended: DD/MONTH/YYYY
Principal's Name:		Telephone Number:
Guidance Counsellor's Name:		Telephone Number:
Last grade successfully completed:		Does this youth have an ISSP? □ Yes □ No
If not attending, describe:		

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8. EMPLOYMENT HISTORY (if applicable)

Is youth currently employed? □ Yes □ No

Has youth been previously employed? □ Yes □ No

Please describe:

9. COURT-RELATED / PROBATION INFORMATION

Is this youth on probation / undertaking ? □ Yes □ No	Expiry Date: DD/MONTH/YYYY
Conditions of probation / undertaking:	
Youth Worker's Name:	Youth Worker's Telephone #:

Does the youth have charges pending? □ Yes □ No

Does the youth have any upcoming court dates? □ Yes □ No

If yes to charges pending or upcoming court dates, please list:

10. RELEVANT FAMILY HISTORY (Please check appropriate boxes)

□ Household Issues	□ Child Youth & Family Services Involvement	□ Addictions
□ Financial Issues	□ Family Violence	□ Trauma
□ Legal Involvement	□ Mental Health	□ Other :

Please provide further detailed information:

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11. SOCIAL HISTORY

List all placements the youth has been in (ie. foster homes, group homes, custody facilities, relatives, etc.), the dates of the placement and the reasons for moving (use additional paper if necessary).

	Placement	Dates	Reason for Move
1.		DD/MONTH/YYYY	
2.		DD/MONTH/YYYY	
3.		DD/MONTH/YYYY	
4.		DD/MONTH/YYYY	
5.		DD/MONTH/YYYY	
6.		DD/MONTH/YYYY	
7.		DD/MONTH/YYYY	
8.		DD/MONTH/YYYY	

12. SERVICE HISTORY

Please list history of services provided / offered to the youth and family and status of same:

	Service	Availed of / Refused	Status (active / inactive)
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

13. DISCHARGE PLAN

What is the anticipated after-care plan?

Are there any special considerations with respect to placement? □ Yes □ No If yes, please explain what they are:

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14. STRENGTHS / SUPPORTS	
Please describe youth's strengths and current supports:	
15. ADDITIONAL INFORMATION (please provide any additional information relevant to this referral:	
16. REFERRAL SOURCE INFORMATION	
Name:	Position:
Address:	
Telephone Number:	Fax Number:
Signature:	Date Completed: DD/MONTH/YYYY

PLEASE ENSURE REFERRAL PACKAGE CHECKLIST IS COMPLETE

FOR OFFICE USE ONLY

Received by: _____ Date Received: DD/MONTH/YYYY

Reviewed by: _____ Date Reviewed: DD/MONTH/YYYY

SIGNATURE: _____ **PRINT:** _____ **DATE:** DD/MONTH/YYYY