Bayfield Treatment Centres Referral Form

Once completed, this referral may be sent to:

Kimberly Baldwin, Director of Service

kbaldwin@bayfield.net
Fax: 613-392-4054

P.O. Box 10, 30 County Rd 39
Consecon, Ontario K0K 1T0

Legal Name of Child: **Date of Birth:**

Preferred Name: **Date of Referral:**

Biological Gender: ☐ Male ☐ Female

Child's Conception of Self: ☐ Male ☐ Female

Gender Identity: ☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ Transgendered

Wardship Status: **Spoken Language(s):**

Ethnicity: **Religion:**

Placing Agency: **Mailing Address:**

Worker/Primary Contact: **Phone Number:**

Fax Number:

E-mail Address:

Family Worker: **Phone Number:**

Fax Number:

E-mail Address:

Legal Guardian: **Phone Number:**

E-mail Address:

Mailing Address:

Current Placement: **Placement Address:**

Phone Number:

LEGAL INVOLVEMENT:

Does this child have any existing criminal charges? If so, please provide details and forward all available police reports and predisposition reports.

Charge(s):

Lawyer Name: **Phone Number:**

Court Date(s): **Court Location:**

Is this child currently involved in family court? If so, please provide details.

Reason(s):

Lawyer Name: **Phone Number:**

Court Date(s): **Court Location:**

Is Child Involved with Probation Services? If so, please provide details and attach probation orders.

Conviction(s):

Condition(s):

Probation Officer: **Phone Number:**

PREVIOUS PLACEMENTS:

Placement	Dates	Reason for Discharge
1.		
2.		
3.		
4.		
5.		

CHILD'S STRENGTHS/ABILITIES / INTERESTS:

1.
2.
3.
4.
5.
6.

BEHAVIOURAL HISTORY:

		Comments
Fire setting:	☐N/A ☐Suspected ☐Confirmed	
Cruelty to animals:	☐N/A ☐Suspected ☐Confirmed	
Property damage:	☐N/A ☐Suspected ☐Confirmed	
Theft:	☐N/A ☐Suspected ☐Confirmed	
Physical aggression:	☐N/A ☐Suspected ☐Confirmed	
Verbal aggression:	☐N/A ☐Suspected ☐Confirmed	
Sexual aggression:	☐N/A ☐Suspected ☐Confirmed	
Targets Male or Female:	☐N/A ☐M ☐F	
Self-harm:	☐N/A ☐Suspected ☐Confirmed	
Truancy:	☐N/A ☐Suspected ☐Confirmed	
Sleep disturbance:	☐N/A ☐Suspected ☐Confirmed	
Running away:	☐N/A ☐Suspected ☐Confirmed	
Eating disorder:	☐N/A ☐Suspected ☐Confirmed	
Enuresis (bed wetting):	☐N/A ☐Suspected ☐Confirmed	
Encopresis (soiling):	☐N/A ☐Suspected ☐Confirmed	
Feces Smearing:	☐N/A ☐Suspected ☐Confirmed	
Drug Use:	☐N/A ☐Suspected ☐Confirmed	
Alcohol Use:	☐N/A ☐Suspected ☐Confirmed	

SERIOUS OCCURENCES FOR LAST 12 MONTHS:

		# SOR's	Comments
#2 SOR:	Serious Injury to the youth		
#3 SOR:	Allegations against staff, foster parents, and temporary care providers		
#4 SOR:	Missing/runaway youth		
#7 SOR:	Serious complaints made about the youth (police charges, assaults, etc.)		
#8 SOR:	Use of physical restraint		

HEALTH AND MEDICAL INFORMATION:

Health Card Number: **OHIP Number:**

Height: ☐Inches ☐Centimeters **Weight:** ☐Pounds ☐Kilograms

		Last Exam Date	Results	Comments
Physical:	☐Y ☐N		☐ **Healthy** ☐ **Concerns**	
Dental:	☐Y ☐N		☐ **Healthy** ☐ **Concerns**	
Hearing:	☐Y ☐N		☐ **Healthy** ☐ **Concerns**	
Vision:	☐Y ☐N		☐ **Healthy** ☐ **Concerns**	
Speech:	☐Y ☐N		☐ **Healthy** ☐ **Concerns**	
Other:			☐ **Healthy** ☐ **Concerns**	

Are there any known Health Problems?

Allergies:	☐Y ☐N	**Comments:**
Tuberculosis:	☐Y ☐N	**Comments:**
STD:	☐Y ☐N	**Comments:**
HIV:	☐Y ☐N	**Comments:**
HEP C:	☐Y ☐N	**Comments:**
Pregnancy:	☐Y ☐N	**Comments:**
Other:	**1.**	**Comments:**
	2.	**Comments:**
	3.	**Comments:**

IMMUNIZATIONS:

Vaccine		Date	Vaccine		Date
Diphtheria:	☐Y ☐N		**Hib:**	☐Y ☐N	
Pertussis:	☐Y ☐N		**Measles:**	☐Y ☐N	
Tetanus:	☐Y ☐N		**Mumps:**	☐Y ☐N	
Polio - IPV:	☐Y ☐N		**Rubella:**	☐Y ☐N	
Polio - VPO:	☐Y ☐N		**Hepatitis B:**	☐Y ☐N	

MENTAL STATUS:

Comments

Intellectual Functioning:
- ☐ Sub Average
- ☐ Average
- ☐ Above Average

Learning Disability:
- ☐ Reading
- ☐ Mathematics
- ☐ Writing

Learning Disorder:
- ☐ Receiving Information
- ☐ Processing Information

Insight Issues:
- ☐ Intuition
- ☐ Introspection
- ☐ Deduction / Reasoning

Memory: ☐Normal ☐Deficit

Concentration: ☐Normal ☐Deficit

ADHD: ☐Y ☐N

FASD:
- ☐ Fetal Alcohol Syndrome
- ☐ Fetal Alcohol Effects
- ☐ Alcohol Related Neurodevelopmental Disorder
- ☐ Partial Fetal Alcohol Syndrome
- ☐ Static Encephalopathy
- ☐ Alcohol-Related Birth Defects

Autism Spectrum Disorder:
- ☐ Autism
- ☐ Asperger Syndrome
- ☐ Pervasive Development Disorder

Hallucinations: ☐Y ☐N

Dissociation: ☐Y ☐N

Psychosis: ☐Y ☐N

Affect: ☐Normal ☐Flat ☐Labile

Mood Disorder:
- ☐ Dysthymia
- ☐ Depression
- ☐ Hypomania
- ☐ Mania
- ☐ Bipolar

Anxiety Disorder:
- ☐ Generalized Anxiety
- ☐ Panic
- ☐ Social
- ☐ Phobia
- ☐ OCD
- ☐ PTSD

Schizophrenia: ☐Y ☐N

Schizoaffective disorder: ☐Y ☐N

Conduct disorder: ☐Y ☐N

Self-Harm: ☐Y ☐N

Suicide Threats: ☐Y ☐N

Suicide Attempts: ☐Y ☐N

Reenactment of trauma: ☐Y ☐N

Nightmares: ☐Y ☐N

Flashbacks: ☐Y ☐N

Risk Taker: ☐Y ☐N

Sleeping Disturbance: ☐Y ☐N

MEDICATION:

Current Medications	Dosage	When/Duration	Reaction/Side Effects
1.			
2.			
3.			
4.			
5.			
6.			
7.			

Past Medications	Dosage	When/Duration	Reason for Discontinuation
1.			
2.			
3.			
4.			
5.			
6.			
7.			

EDUCATION HISTORY:

Student OEN:

IPRC Identification:

Current Grade:

Name of Last School Attended:

Address of Last School Attended:

Contact Name and Position:

Telephone Number:

Fax Number:

Email Address:

Comments

Does the child enjoy school? ☐Y ☐N

Assaulted peer/teacher/staff? ☐Y ☐N

1:1 staffing in the classroom? ☐Y ☐N

Schoolwork/homework refusal? ☐Y ☐N

School difficult place for child? ☐Y ☐N

Please provide a copy of the student's most recent Report Card

REASON FOR REFERRAL:

Please briefly explain why is the child being referred to Bayfield at this time (including evolution of presenting problems)?

Services to be Purchased:

MCYS Licensed Children's Residence Placement:	☐ $348.00 per day
Family Based Care (foster) Placement:	☐ $193.80 per day
Bayfield Private School Enrolment:	☐ $93.97 per day
Individual Psychiatric and Psychological Services:	☐ $65.05 per day

GUARDIAN'S PLACEMENT EXPECTATIONS:

Please indicate the initial placement priorities and/or the key indicators that the child/youth will be ready for discharge?

1.

2.

3.

4.

ESTIMATED LENGTH OF PLACEMENT:

☐ Short-term Crisis / Assessment ☐ 6 months to 1 year ☐ Long-term (greater than a year)

Where is the Child/Youth likely to be discharged to?

Comments:

ADDITIONAL COMMENTS:

Placement needed by:

Date referral submitted:

Referral completed by:

Position of person making referral:

Name of person to reply to:

Contact information of person to reply to:

Please forward all previous Psychological, Psychiatric, Discharge, Neuropsychological, Endrcrinological, Medical and School assessments/reports, as well as the youth's Social History, prior to admission.