Sioux Lookout First Nations Health Authority

PAEDIATRIC SERVICES INTAKE/REFERRAL FORM (0-17 YEARS 364 DAYS)

CENTRALIZED INTAKE FOR THE FOLLOWING PARTNER AGENCIES:

- *SLFNHA – Developmental Services*
- *NHU (North Words Preschool SLP Program)*
- *SLFNHA – Primary Care Team*
- *FIREFLY*

MANDATORY SECTION:

Client/Parent/Guardian Signature: _____ Date: _____

OR: *Referring Party has spoken* **directly** *to client/parent/guardian to discuss this referral and has received* ***verbal consent*** *to initiate this referral. -->* ***Referring Party's Initials:*** _____

Name of referring party: _____ Date: _____

Agency/School: _____ Phone: _____

Email address: _____ Fax: _____

Client Information

Name: _____ (First) _____ (Last) Date of Birth: _____ MMM _____ DD _____ YYYY

Anishinaabe Name: _____ Clan: _____

Gender: ☐ M ☐ F ☐ Declined ☐ Unknown ☐ Other: _____

Health Card: _____ (# + Version Code)

Client #: _____ (SLFNHA use only)

Status Card #: _____ ☐ N/A

NOTE: **REQUIRED**

Band Name: _____

Preferred Language: ☐ English ☐ French ☐ Indigenous

Interpreter Required? _____ *(If yes, for what language)*

Physical Address: _____

Mailing Address: ☐ (Check if same as previous) _____

Phone: _____ Email: _____

Please Note: *If this is a self-referral from a youth aged between 12-15.99 yrs of age, the referring party should attempt to encourage the child/youth to involve their parent/guardian in this process, to ensure best possible outcomes.*

- If this referral is directly from a Child/Youth 12 years or older, do they give permission for the provider to involve their parent(s) in the intake service: ☐ Yes ☐ No

Please submit the fully completed form to our Central Intake Fax Line at 1 807 737 8130

Client's Name	Date of Birth (MM/DD/YYYY)

Parent/Caregiver Contact Information

Parent/Caregiver: _____ Relationship to Client: _____

Physical Address: _____

Mailing Address: ☐ (Check if same as previous)

Home Phone: _____ Cell: _____ Daytime #: _____

Preferred method of contact? _____

If family/client does not have phone, OK to leave non-detailed message at: _____ (phone number) Description: _____

*If the client's caregiver (listed above) is **not** his/her legal guardian, or the client is in the care of a Child Welfare agency:*

Agency Name: _____ Agreement Type: _____

Worker's Name: _____ Phone: _____

Email Address: _____ Fax: _____

School Information: Does this client have an IEP? ☐ No ☐ Yes

School/Child Care Centre: _____ Grade:

Referral Selections: Identify which program(s) the client is being referred to:

Please indicate priority level: ☐ **URGENT (1-3 Weeks)** ☐ **1-3 Months** ☐ **Waitlist**

Pediatric Services

- ☐ Audiology
- ☐ Behavioral Therapy
- ☐ Complex Care Case Coordination
- ☐ Cultural Liaison – Traditional Services
- ☐ Diabetic Foot Care
- ☐ Early Years Screening
- ☐ FASD Assessment
- ☐ FASD Support Worker
- ☐ Hepatitis C Treatment
- ☐ Kinesiology
- ☐ Nutrition Consult
- ☐ Occupational Therapy
- ☐ Physiotherapy
  - ☐ *Pelvic Floor (Ages 14yrs+, parental consent needed for below age 16yrs)
  - ☐ Vestibular/Vertigo
- ☐ Pharmacy
- ☐ Psychiatry
- ☐ Social Worker
- ☐ Speech Language Pathology
- ☐ Transitional Youth Program (16 and older with Developmental Disability)

☐ Developmental Pediatrician

(Physician, Nurse Practitioner, or Allied Health Care Professional who is requesting this service must attach referral letter)

Developmental Psychology: Please indicate 1 or more services being requested.

- ☐ Psychology Consultation
- ☐ Autism Assessment
- ☐ Developmental Delay Assessment
- ☐ Psycho-Educational Assessment

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Client's Name	Date of Birth (MM/DD/YYYY)

*Please Note: All services can be **requested for consideration**; however, the client's suitability/eligibility for some programs will be determined by their respective agencies and acceptance of the referral cannot be guaranteed.*

Reason for Referral: Please provide a brief description of the problem/concern:
(To assist in the referral process, if the client consents, please also attach any relevant medical, psychological, rehabilitation, behavioral assessments and reports etc., including those that identify a previous diagnosis)

Other Service Providers, Agencies, Physicians, Community Resources Involved? Please list as many as possible:

Does the client/family require any assistance or accommodations in order to participate in a **telephone meeting** with an Intake worker? (i.e. Access to a telephone, Wheelchair Accessibility, documents in large type or Braille, modified speed and volume of speech, specific appointment scheduling to allow for regular medical routines etc.). *If yes, please have the client/family member describe what accommodations would best assist them:* ☐ No

Does the client/family require any assistance or accommodations in order to participate in **any future services** the client/family may select after the intake meeting is completed? (i.e. Wheelchair Accessibility, documents produced in large type or Braille, access to text-to-speech software, specific appointment scheduling to allow for regular medical routines, meetings held in their own home etc.) ☐ No

Any other information that is important or helpful regarding this referral?

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