



**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.



Mental Health and Addictions

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Name: _____

HCN/MCP: _____

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?

Multiple empty lines for text entry.

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:

Multiple empty lines for text entry.

Mental Health: Check the appropriate boxes and please describe.

- | | | |
|--|--|---|
| <input type="checkbox"/> Self-Harm | <input type="checkbox"/> Suicidal Ideation | <input type="checkbox"/> Past Suicidal Behavior |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> Cognitive Impairment |
| <input type="checkbox"/> Medication Compliance | <input type="checkbox"/> Emotional Regulation | <input type="checkbox"/> Fetal Alcohol Spectrum Disorder (FASD) |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Psychosis | <input type="checkbox"/> Conduct Disorder |
| <input type="checkbox"/> Attention Deficit Hyperactivity Disorder (ADHD) | <input type="checkbox"/> Oppositional Defiant Disorder | <input type="checkbox"/> Bipolar Disorder |
| <input type="checkbox"/> Other (specify): | <input type="checkbox"/> Elimination Disorders | |

Please describe:

Multiple empty lines for text entry.

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

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Trauma: Check the appropriate boxes and please describe.						
<input type="checkbox"/> Emotional Abuse	<input type="checkbox"/> Physical Abuse	<input type="checkbox"/> Sexual Abuse	<input type="checkbox"/> Medical Trauma	<input type="checkbox"/> Witness to Violence	<input type="checkbox"/> Witness / Victim of Criminal Activity	<input type="checkbox"/> Post Traumatic Stress Disorder
<input type="checkbox"/> Other (specify):						
Please describe:						
Social / Behavior / Development Considerations:						
<input type="checkbox"/> Violent Behavior	<input type="checkbox"/> Aggression	<input type="checkbox"/> Self Esteem	<input type="checkbox"/> Peer Interaction	<input type="checkbox"/> Social Isolation		
<input type="checkbox"/> Running / Absent Without Permission	<input type="checkbox"/> Impulsivity	<input type="checkbox"/> Inability to Focus	<input type="checkbox"/> High Risk Behaviors (including sexual)			
<input type="checkbox"/> Autism Spectrum Disorder	<input type="checkbox"/> Other (specify):					
Please Describe:						
Physical Issues:						
<input type="checkbox"/> Visually Impaired	<input type="checkbox"/> Hearing Impaired	<input type="checkbox"/> Mobility				
Please describe:						
Does youth require assistance to complete self-care tasks? <input type="checkbox"/> Yes <input type="checkbox"/> 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	
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Name: _____
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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? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Comments:			
Does youth use substances and/or gamble with anyone he/she lives with? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Comments:			
Is youth dependent on alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Is youth dependent on high dose benzodiazepines (greater than 50mg equivalent)? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Is youth dependent on opioids? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Has youth ever been hospitalized as a result of substance use/abuse? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Has youth ever overdosed? <input type="checkbox"/> Yes <input type="checkbox"/> No (if yes, please provide details)			
Has youth experienced symptoms such as seizures or hallucinations when stopped using substance(s) in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please provide details on substance used and associated symptoms:			

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CRMS Number: _____

Is youth requesting admission to a withdrawal management bed? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, have attempts been made in the past to abstain from substances or drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No
What were the results?
Is there an option for withdrawal management support in youth's community? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is youth currently prescribed methadone? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please provide details (ie. physician, pharmacy, dosage, etc.):
Does the youth use tobacco products? <input type="checkbox"/> Yes <input type="checkbox"/> No
Does the youth use nicotine replacement therapies? <input type="checkbox"/> Yes <input type="checkbox"/> 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: _____

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Type of Allergy		Allergy Information (include all food allergies):	
			Reaction
Does youth carry an Epi-Pen? <input type="checkbox"/> Yes <input type="checkbox"/> 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:			
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Seizures	
<input type="checkbox"/> Brain Injury	<input type="checkbox"/> Dietary	<input type="checkbox"/> Neurological Disorders	
<input type="checkbox"/> Other (specify):			
Has youth ever been tested for HIV? <input type="checkbox"/> Yes <input type="checkbox"/> No		Has youth ever been tested for Hepatitis C? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No			

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Name: _____
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Date of Birth: _____ DD/MONTH/YYYY
CRMS Number: _____

Relationship to Youth: <input type="checkbox"/> Birth Parent <input type="checkbox"/> Adoptive Parent <input type="checkbox"/> Step-Parent <input type="checkbox"/> Grandparent <input type="checkbox"/> Foster Parent <input type="checkbox"/> Other:		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Common Law <input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/>			
Relationship to Youth: <input type="checkbox"/> Birth Parent <input type="checkbox"/> Adoptive Parent <input type="checkbox"/> Step-Parent <input type="checkbox"/> Grandparent <input type="checkbox"/> Foster Parent <input type="checkbox"/> Other:		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Common Law <input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/>			
Relationship to Youth: <input type="checkbox"/> Birth Parent <input type="checkbox"/> Adoptive Parent <input type="checkbox"/> Step-Parent <input type="checkbox"/> Grandparent <input type="checkbox"/> Foster Parent <input type="checkbox"/> Other:		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Common Law <input type="checkbox"/> Separated	
7. SCHOOL INFORMATION			
Is this youth attending school? <input type="checkbox"/> Yes <input type="checkbox"/> No		Grade: _____	Date last attended: _____ DD/MONTH/YYYY
If yes, Name of School: _____			
Principal's Name: _____		Telephone Number: _____	
Guidance Counsellor's Name: _____		Telephone Number: _____	
Last grade successfully completed: _____		Does this youth have an ISSP? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If not attending, describe: _____			

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8. EMPLOYMENT HISTORY (if applicable)		
Is youth currently employed? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Has youth been previously employed? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Please describe:		
9. COURT-RELATED / PROBATION INFORMATION		
Is this youth on probation / undertaking? <input type="checkbox"/> Yes <input type="checkbox"/> No	Expiry Date: DD/MONTH/YYYY	
Conditions of probation / undertaking:		
Youth Worker's Name:	Youth Worker's Telephone #:	
Does the youth have charges pending? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Does the youth have any upcoming court dates? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes to charges pending or upcoming court dates, please list:		
10. RELEVANT FAMILY HISTORY (Please check appropriate boxes)		
<input type="checkbox"/> Household Issues	<input type="checkbox"/> Child Youth & Family Services Involvement	<input type="checkbox"/> Addictions
<input type="checkbox"/> Financial Issues	<input type="checkbox"/> Family Violence	<input type="checkbox"/> Trauma
<input type="checkbox"/> Legal Involvement	<input type="checkbox"/> Mental Health	<input type="checkbox"/> 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

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