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
   c/o 50 Union Street
   Grand Falls-Windsor, NL
   A2A 2E1
   PH: (709) 489-6193/6268
   ytcreferral@centralhealth.nl.ca

   Referral Coordinator
   Youth Mental Health Treatment Centre
   Eastern Health
   760 Topsail Road, Mount Pearl, NL
   A1N 3J5
   PH: (709) 752-4529
   FAX: (709) 752-4989

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 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 489-6193 or 489-6268 to complete a telephone intake.

Youth's Name: _____ Date: _____

Youth Treatment Centre Referral Form

First Name: _____

Last Name: _____

Date of Birth: _____

CRMS #: _____

MCP #: _____

1. Youth Information		
Current Street Address:		
City:	Province:	Postal Code:
Telephone Number:	Telephone Number:	
Gender:	Age:	Language:
CYFS 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: _____	
List any language other than English spoken at home:		
First Nations Identity (if applicable):		
Aboriginal Status (if applicable):	Band Member (if applicable):	
Band Name (if applicable):	Status Number (if applicable):	
List any cultural or spiritual needs this youth may have:		

2. Reason for Referral
What are the major areas to be addressed while at the Youth Treatment Centre?

Youth's Name: _____ Date: _____

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

Learning Needs:

☐ School Attendance ☐ Behaviour at School ☐ Lack of Educational Supports ☐ Peer Groups

☐ Learning Disability (specify): _____

☐ Other (specify) _____

Please describe: _____

_____

_____

Mental Health: check the appropriate boxes and please describe.

☐ Medication Compliance	☐ Bipolar Disorder	☐ ADHD
☐ Self-Harm	☐ Psychosis	☐ Eating Disorder
☐ Suicidal Ideation	☐ Emotional Regulation	☐ FASD
☐ Past Suicidal Behaviour	☐ Oppositional Defiant Disorder	☐ Elimination Disorders
☐ Anxiety	☐ Conduct Disorder	☐ Other (specify):
☐ Depression		

Please describe:

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/Behavioural/Developmental Considerations

☐ Low Self Esteem	☐ Impulsivity	☐ Violent Behaviour
☐ Inability to focus	☐ Autism Spectrum Disorder	☐ High Risk Behaviour (including sexual)
☐ Peer Interaction	☐ Running/AWOL	☐ Other (specify):
☐ Social Isolation	☐ Aggression	

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:

Youth's Name: _____ Date: _____

Addictions (substance abuse/gambling):

Substance	Amount used	Route of administration	Frequency of use	Age first used	Date last used

Gambling Type	Frequency	Date last Gambled	Start Age

Comments:

In youth's current residence, are there alcohol/substance abuse and/or gambling issues? ☐ Yes ☐ No

Comments:

Does youth use alcohol/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 (>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)

Comments:

Has the youth experienced symptoms such as seizures or hallucinations when stopped using alcohol/substances in the past?
☐ Yes ☐ No If yes, please provide details on substance used and associated symptoms:

Youth's Name: _____ Date: _____

Is youth requesting admission to a withdrawal management bed? ☐ Yes ☐ No
If yes, have attempts been made in the past to abstain from alcohol 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 (i.e. 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 Phone #:
Other attending Health Care Practitioners	**Contact Phone Number**
Name:	Telephone #:
Name:	Telephone #:
Name:	Telephone #:
Name:	Telephone #:

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**
Name	**Dosage**	**Name**	**Dosage**

List any special medical needs of this youth:

☐ Asthma	☐ Diabetes	☐ Seizures	☐ Brain Injury
☐ Dietary	☐ Neurological Disorders	☐ Other (specify):	

Youth's Name: _____ Date: _____

Please describe:	
Has youth ever been tested for HIV? ☐ Yes ☐ No	Has youth 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 #:	Other Telephone #:	
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 #:	Other Telephone #:	
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 #:	Other Telephone #:	
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 youth attending school? ☐ Yes ☐ No	Grade:	Date last attended:
Principal's Name:	Telephone #:	
Guidance Counsellor's Name:	Telephone #:	
Last grade successfully completed:	Does youth have an ISSP?	
If not attending, describe:		

Youth's Name: _____ Date: _____

8. Employment History (if applicable)
Is youth currently employed? ☐ Yes ☐ No
Has youth been previously employed? ☐ Yes ☐ No
Please describe:

9. Court Relate/Probation Information	
Is youth on probation/undertaking? ☐ Yes ☐ No	Expiry Date:
Conditions of probation/undertaking:	
Charges for which probation received:	
Youth Worker Name:	Youth Worker's Telephone #:
Does youth have charges pending? ☐ Yes ☐ No	Does youth have any upcoming court dates? ☐ Yes ☐ No
If yes, please provide details:	

10. Relevant Family History (Please check appropriate boxes)		
☐ Housing Issues ☐ Financial Issues ☐ Legal Involvement	☐ CYFS Involvement ☐ Family Violence ☐ Mental Health	☐ Addictions ☐ Trauma ☐ Other:
Please provide further detailed information:		

11. Social History

List all placements the youth has been in (i.e. 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.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Youth's Name: _____ Date: _____

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 circumstances with respect to placement? ☐ Yes ☐ No
If yes, please explain what they are:

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 #:	Fax #:
Signature:	Date Completed:

For Office Use Only	
Received by:	Date received:
Received by:	Date received:

Youth's Name: _____ Date: _____