



Country Haven Acres ~ Residential Services Inc.
 968 Hwy 518 East, Emsdale, ON P0A 1J0
 Phone (705)636-0008 ~ Fax (705)636-0009

Residential Program Referral Form

Referring Agency: _____
 Address: _____
 Telephone: _____
 Worker: _____
 Referral Date: _____

1. Client information

Name of Client: Given: _____ Middle: _____ Surname: _____
 Date of Birth: _____ Age: _____ Sex F/M: _____
 Present Address: _____

Client Living With: _____
 Relationship to Client: _____
 Address: _____

 Telephone: H: _____ W: _____

Legal guardian {if different from above}

| | |
|------------------------|---------------------|
| Birth Parents _____ | Name: _____ |
| CAS Non-Ward _____ | Address: _____ |
| Adoptive Parents _____ | _____ |
| CAS Society Ward _____ | Telephone: H: _____ |
| Single mother _____ | W: _____ |
| CAS Crown Ward _____ | |
| Single Father _____ | |
| Other (specify) _____ | |

Language:
 English _____ Spoken _____ Written _____
 French _____ Spoken _____ Written _____
 Other _____ Spoken _____ Written _____

Religion: _____



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Native Status Yes ___ No ___ Band _____

Education:
 Previous School and Teacher: _____ grade/level _____
 Phone Number: _____
 School Board: _____
 Level of Success Low _____ Average _____ High _____
 On-going behaviours and or triggers, strategies uses or attempted: _____

 Learning difficulties and strategies tried: _____

 School Number OSR: _____
 IEP Number: _____
 Psych-ed assessment: YES: _____ NO: _____ (Please include if available)
 Report Cards (Please include most recent): YES: _____ NO: _____

Medical:
 Date of last Optical Appointment: _____
 Are there any physical health issues?

 Allergies: YES _____ NO _____
 If yes please list and severity in treatment:

 Health Card Number: _____
 Medication: YES _____ NO _____ Date Started: _____
 If Yes, Please indicate what type, dosage, time of administration and for what reason:

Medical Cont'd:



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Prescribing Doctor's name and number: _____

Current and past General Practitioners:

Name: _____ Number: _____

Name: _____ Number: _____

Name: _____ Number: _____

Name: _____ Number: _____

Specialized Medical Services required past and present:

Immunization Record: YES _____ NO: _____ (Please include with package)

Prerequisite for Initial Doctor's Set-up

| | | |
|---|----------------|--|
| Ongoing Medical Concerns and or problems. | | |
| Previous conditions that hospitalization was required. (Please include dates) | | |
| Previous medical conditions requiring M.D regular visits. | | |
| Past surgeries and aesthetic exposure. (Date & Surgeons names) | | |
| Prior hospitalizations. (Reasons and dates) | | |
| Family history of medical conditions. (if know age that illness started & if in pass please include date) | Mother | |
| | Father | |
| | Brother(s) | |
| | Sister(s) | |
| | Aunt(s) | |
| | Uncle(s) | |
| | Grandfather(s) | |
| | Grandmother(s) | |
| Cousin(s) | | |



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| | |
|--|---|
| Prerequisite for Initial Doctor's Set-up Cont'd | |
| Specialist which are currently seen. | |
| Social History | |
| Smoking (Year started, quit, and # of times quit) | |
| Alcohol Consumption | YES____ or NO____ # of years:____ Amount consumed in a week: |
| Other Comments of concern. | |
| Date of last Medical | |

| |
|---|
| <p>Prerequisite for Initial Dental Set-up</p> <p>Have there been hospitalization in the past two(2) years: _____</p> <p>Has there been surgery of the face or Jaw: _____</p> <p>Is there any heart murmurs or rheumatic fever: _____</p> <p>Allergic reaction to any medication: _____</p> <p>Hearing difficulties: Yes____ No:____</p> <p>Frequent or severe headaches, earaches or throat infections please specify: _____</p> <p>_____</p> <p>Has there been any troubles stopping bleeding: _____</p> <p>When was the last dental visit: _____</p> <p>Ever had local anaesthetic: Yes____ No:____ Any complications: _____</p> <p>Date of last dental: _____</p> |
|---|

Reason for referral and presenting problem:



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Problem Checklist (*Adapted from the CSN intake problem Checklist)

Please check any of the following, which apply at the time of assessment:

1. Past (has occurred, but not within the last six months)
2. Current (within the last six months)
3. Both past and current

| | 1 | 2 | 3 | Comments |
|---|-----------------------|-----------------------|-----------------------|----------|
| A) <u>Home – family Circumstances</u> | | | | |
| 1. Acting out (home related) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 2. Relationship problems (home related) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 3. Emotional problems (home related) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 4. Significant separation from family | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 5. Death of a significant other | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 6. Family disruptions (separation, etc..) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 7. family conflict | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 8. Wife assault (family violence) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 9. Family alcoholism-substance abuse | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 10. Multiple moves | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 11. Financial stress | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 12. On welfare (GWA< FBA) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 13. Family health – injury problems | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 14. Family emotional – psychiatric problems | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 15. Family legal problems | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 16. Family involvement with multiple agencies | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |



Please check any of the following, which apply at the time of assessment:

1. Past (has occurred, but not within the last six months)
2. Current (within the last six months)
3. Both past and current

B) School - Education

- | | | | | |
|---|-----------------------|-----------------------|-----------------------|-------|
| 1. Acting out (school related) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 2. Relationship problems (school related) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 3. Emotional problems (school related) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 4. Marked School underachievement | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 5. Diagnosed learning problems | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |

C) Behaviour – Traits:

- | | | | | |
|--|-----------------------|-----------------------|-----------------------|-------|
| 1. Inappropriate sexual behaviour | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 2. Actively rejecting help | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 3. Alcohol – substance abuse | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 4. Oppositional – defiant | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 5. Aggressive | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 6. Temper tantrums | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 7. Physical- sensory handicap | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 8. Significant physical illness - injury | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |

D) Community

- | | | | | |
|--|-----------------------|-----------------------|-----------------------|-------|
| 1. Acting out (community related) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 2. Relationship problems (Community related) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 3. Emotional problems (community related) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |



Please check any of the following, which apply at the time of assessment:

1. Past (has occurred, but not within the last six months)
2. Current (within the last six months)
3. Both past and current

E) Offences

- | | | | | |
|-----------------|-----------------------|-----------------------|-----------------------|-------|
| 1. Fire setting | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 2. Vandalism | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 3. Theft | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 4. probation | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |

F) Peer relations

- | | | | | |
|--|-----------------------|-----------------------|-----------------------|-------|
| 1. Relationship problem (peer related) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 2. Some delinquent friends | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 3. Change in peer group | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |

G) Symptoms:

- | | | | | |
|-------------------------------|-----------------------|-----------------------|-----------------------|-------|
| 1. Nightmare or panic attacks | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 2. Somatizing | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 3. Enuresis or Encopresis | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 4. Hyperactive | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 5. Delusional thinking | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 6. Eating disorder | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 7. Depressed | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 8. Psychiatric problems | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |



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1. Past (has occurred, but not within the last six months)
2. Current (within the last six months)
3. Both past and current

H) Abusive and high Risk behaviour

- | | | | | |
|---|-----------------------|-----------------------|-----------------------|-------|
| 1. Destructive | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 2. Sexually Assaultive behaviour | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 3. Assaultive behaviour towards authority | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 4. Conviction for violent offences | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 5. Incident involving use of weapons | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 6. Suicidal attempts – ideations | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 7. Self inflicted physical abuse | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 8. Running away | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |

I) Abused

- | | | | | |
|--|-----------------------|-----------------------|-----------------------|-------|
| 1. Physically abused (by caretaker) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 2. Sexually abused(By Caretaker) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 3. Emotionally Abused (by caretaker) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 4. Assaulted – molested (by caretaker) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 5. Threatened (by non-caretaker) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |

Problem checklist completed By; _____ Date: _____

Desired Change – “Treatment objectives”



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Please identify goals you have to have achieved

Goal#1

Goal#2

Goal#3

Plan for child upon discharge from program.

Plan of care Meeting(s) will be attended by? (Parents, Case worker, legal guardians etc.)

| <u>Name</u> | <u>Relationship</u> | <u>Phone</u> |
|-------------|---------------------|--------------|
| <hr/> | <hr/> | <hr/> |
| <hr/> | <hr/> | <hr/> |
| <hr/> | <hr/> | <hr/> |
| <hr/> | <hr/> | <hr/> |
| <hr/> | <hr/> | <hr/> |



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Supporting and Monitoring Services

| Name of Agency | Type of service | Presently involved | Duration | Name of worker | Outcome |
|----------------|-----------------|--------------------|----------|----------------|---------|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

*attach release of information form for purpose of sharing information.



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Assessment

| Type of Assessment | Date(s) | Agency | Copy provided with this referral |
|--------------------|---------|--------|----------------------------------|
| | | | |
| | | | |
| | | | |

Provide all reports available with referral.

Out of home placement

| Type of placement | Duration | Reason for placement | Outcome |
|-------------------|----------|----------------------|---------|
| | | | |
| | | | |
| | | | |
| | | | |



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School history of client

| Year | School | Regular or special program | Comments |
|------|--------|----------------------------|----------|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Approved Call list (First, Last and Number):

Restricted Call List:



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Other additional information not mentioned in this referral.

Family information

| | Mother | Father | Other (Step- Parent, foster parent etc.) | Other (Step- Parent, foster parent etc.) |
|-----------------------|--------|--------|--|--|
| Name | | | | |
| DOB (m/d/y) | | | | |
| Maiden name | | | | |
| Address | | | | |
| City | | | | |
| Province | | | | |
| Postal code | | | | |
| Home phone | | | | |
| Work phone | | | | |
| Language | | | | |
| Religion | | | | |
| Marital status | | | | |
| Education | | | | |
| Income Source | | | | |
| Relationship to child | | | | |



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Marital information or parent relationship

List all other family members and any other significant persons in relation to the client.

| Name | Relationship to client | Age | M/F | Lives Home Yes/No | Employment or school level |
|------|------------------------|-----|-----|-------------------|----------------------------|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Identified Family Problems.

| Situation | Yes | No | Who |
|----------------------------|-----|----|-----|
| Alcohol abuse | | | |
| Drug abuse | | | |
| Conflict with the law | | | |
| Physical violence (spouse) | | | |
| Physical violence (child) | | | |
| Psychiatric disorder | | | |
| Psychological disorder | | | |
| Suicidal attempt | | | |
| Other | | | |



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Family History and functioning.

Additional Family Information.

Family Genogram.

Please attach all existing reports regarding the client (Ex: school reports, psycho-social assessments, social history etc..)

Signature of persons completing this referral