CPRI
CHILD & PARENT RESOURCE INSTITUTE

Outpatient Referral Form

Ontario

The Child and Parent Resource Institute (CPRI) is directly operated by the Ministry of Children, Community and Social Services. CPRI provides provincial, highly specialized, trauma-informed assessment and intervention services for children and youth of Ontario with complex combinations of special needs including severe behavioural and emotional challenges, mental health and developmental disabilities, and autism.

Services are provided through a short-term, inpatient residential and/or community basis, and are based on a partnership model with community service providers. Services may include interdisciplinary assessment, consultation, and initial stages of treatment to children and youth who are at risk of displacement from home, school and/or community followed by transition of recommended treatment strategies to community partners.

The Child, Youth and Family Services Act which governs the services we provide has specific regulations around consent to service. All CPRI services are voluntary. This means that a child/youth must provide assent for services (with guardian consent) **or** consent if they are determined to have the capacity to do so.

Generally, local services available to support a child/youth in their home community are accessed first before a referral to CPRI is considered. This may include a paediatrician, psychiatrist, or a child & youth mental health/developmental service provider.

Inpatient Referrals should be submitted through your county's Single Point of Access Agency.

Referral Form Checklist

It is important to complete all sections accurately. This information is used to assess appropriate services for the child/youth.

☐ Part A - Complete and Signed

- ☐ Reports Attached – Reports are used to assess appropriate services

☐ **Part B - Complete and Signed by Attending Physician**

☐ Part C - Consent Forms complete and signed - See sample and guidelines for important information

☐ Attach additional pages as required at any point in the referral package

Referral Form must include Part A, B and C.

PLEASE ENSURE YOU COMPLETE ALL PAGES OF THIS FORM.

Completed packages or questions can be emailed to: CPRI.Intake@ontario.ca
Fax (519) 858 2115

PART A

REFERRAL INFORMATION:

☐ Hospital ☐ Regional Service Resolution Agency ☐ Mental Health Lead Agency

☐ Special Needs Coordinating Agency ☐ Physician

☐ Other (please specify) _____

CURRENT COMMUNITY CASE MANAGER/SERVICE COORDINATOR FOR CHILD/YOUTH:

Name: _____

Agency: _____

Mailing Address: _____

E-mail: _____

Telephone Home: _____ Work: _____ Cell: _____

Family/guardian is aware of this referral? ☐ Yes ☐ No

Child/youth is aware of this referral? ☐ Yes ☐ No

Is the child/youth agreeing to receiving treatment at CPRI? ☐ Yes ☐ No ☐ Not Sure

CHILD DATA

Name of Child: _____ Preferred Name/Otherwise Known As: _____

Date of Birth: _____

Sex: ☐ Male ☐ Female

Gender Identity: ☐ Male ☐ Female ☐ X

Languages Spoken: _____ Languages Understood: _____

Interpreter Required: ☐ Yes ☐ No

Child's Current Address: _____

City: _____

Postal Code: _____ Telephone: _____

Health Card Number: _____ Version Code: _____ Expiry Date: _____

Currently Living with:
(Check one)

☐ Both Parents ☐ Mother ☐ Father ☐ Guardian(s) ☐ Relative ☐ Step Parent

☐ Foster Home ☐ Group Home ☐ Hospital ☐ Adoptive Parents

Who resides in the home: _____

Living/Placement Arrangement at risk of terminating/about to change (Check one)

☐ No

☐ Yes (please specify) _____

PARENT/LEGAL GUARDIAN 1: _____

Current Address (if different from above): _____

Postal Code: _____ E-mail: _____

Telephone Home: _____ Work: _____ Cell: _____

Is there a formal custody agreement? ☐ No ☐ Yes (if yes, please attach)

Has access to child/youth ☐ Full ☐ Limited ☐ None

Has access to child/youth health/educational information ☐ Full ☐ Limited ☐ None

PARENT/LEGAL GUARDIAN 2: _____

☐ N/A

Current Address (if different from above): _____

Postal Code: _____ E-mail: _____

Telephone Home: _____ Work: _____ Cell: _____

Is there a formal custody agreement? ☐ No ☐ Yes (if yes, please attach)

Has access to child/youth ☐ Full ☐ Limited ☐ None

Has access to child/youth health/educational information ☐ Full ☐ Limited ☐ None

CONSIDERATIONS OF DIVERSITY AND ACCESSIBILITY:

We value and respect the diversity of the individuals and families with whom we partner.

Please indicate any considerations for planning and/or service delivery. (Check those that apply)

☐ N/A	☐ Physical Health	☐ Metis
☐ Language	☐ Sexual Orientation	☐ Identify as an Indigenous Person
☐ Culture	☐ First Nations	☐ Other
☐ Religion	☐ Inuit	Comment: _____

REASON FOR REFERRAL:

Provide an overview of the current situation that has led to this referral (focus on the past 3 months).

HIGH RISK BEHAVIOURS OR SAFETY CONCERNS:

Describe in detail any high risk behaviour or safety concerns:

GOALS OF SERVICE:

Describe the **family's view** of what is needed and what they hope to achieve:

Describe the **child/youth's view** of what is needed and what they hope to achieve:

EDUCATION:

Community School: _____

School Board: _____

Grade: _____ Contact Name: _____ School Contact Number: _____

Is the child/youth Exceptionally Identified?

☐ Yes (list type of Exceptionality): _____ ☐ No ☐ Unknown

Is the child/youth diagnosed with a Learning Disability?

☐ Yes (list type of Learning Disability): _____ ☐ No ☐ Unknown

Please attach the following. If not available, indicate N/A.

Current Identification Placement Review Committee (IPRC)? ☐ N/A

Current Individual Education Plan (IEP)? ☐ N/A

Behaviour Plan? ☐ N/A

Safety Plan? ☐ N/A

Psychological/Psychoeducational assessment (intelligence, academic achievement)? ☐ N/A

Speech Language Assessment? ☐ N/A

Occupational Therapy Assessment? ☐ N/A

Report Cards? ☐ N/A

Suspension Information? ☐ N/A

COGNITIVE FUNCTIONAL LEVEL:

☐ Uncertain (no concerns) ☐ Normal ☐ Global Developmental Delay (GDD)

☐ Uncertain (suspected delay) ☐ Gifted

☐ Intellectual Disability (ID)/ Developmental Disability (DD)

HEALTH INFORMATION:

Has your child ever been hospitalized? ☐ Yes (please specify) ☐ No

Hospital	Date	Reason (Mental Health and/or Physical Health Reason)

Family Physician:_____Phone Number:_____

Email: _____

Paediatrician: _____Phone Number:_____

Email: _____

Psychiatrist: _____Phone Number:_____

Email: _____

Allergies: ☐ Yes ☐ No Known Allergies ☐ No Known Drug Allergies

Please provide a list of non-prescribed medication currently used (e.g. over the counter, seasonal medications, alternative, complimentary or natural drugs/supplement) AND any concerns for allergies to medications, food, tape, latex, environmental etc.:

_____

PAST/PRESENT AGENCY/CLINICIAN INVOLVEMENT:

- Please identify all agency involvement that the child/youth/family has had (past and present and waitlist).

(Check those that apply)	Past	Present	Waitlist	Report Attached	Agency Name/Address	Contact Person/ Phone Number
Children's Aid Society	☐	☐	☐	☐		
Children's Mental Health Agency	☐	☐	☐	☐		
Hospital Services	☐	☐	☐	☐		
Neurology	☐	☐	☐	☐		
Home/Respite Services	☐	☐	☐	☐		
Private Services	☐	☐	☐	☐		
Psychiatry	☐	☐	☐	☐		
Psychology	☐	☐	☐	☐		
Occupational Therapy	☐	☐	☐	☐		
Speech and Language	☐	☐	☐	☐		
Social Work	☐	☐	☐	☐		
Developmental Pediatrician	☐	☐	☐	☐		
Behaviour Services	☐	☐	☐	☐		
Pharmacy - medication profile (obtain from local pharmacy)	☐	☐	☐	☐		
Other Agencies/Services	☐	☐	☐	☐		
Other Agencies/Services	☐	☐	☐	☐		
Other Agencies/Services	☐	☐	☐	☐		

PART B

To be completed and signed by the current community physician

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Goal of Referral:

Health Information: Please list any medical and/or psychiatric diagnoses ☐ Does not apply

Professional/Confirmed or Suspected Diagnosis	By Whom/When:

Health History: Please list medical investigations and date of investigation below.

Type of Investigation	Date of Investigation
☐ MRI	
☐ EEG	
☐ Blood Work	
☐ Genetic Testing	
☐ ECG	
☐ Allergies (known)	
☐ Drug Allergies	
☐ Other:	

Additional and Relevant Background Information:

Print Name of Referring Physician: _____

Address: _____

Email: _____

Phone Number: _____ OHIP billing number: _____

Signature of Referring Physician: _____ Date: _____

Available for consultation ☐ Yes ☐ No

Available for follow up ☐ Yes ☐ No

Please Provide any other medication (e.g. over the counter drugs, seasonal drugs, alternative, complimentary or natural drugs/supplement, food, tape, latex, environmental etc. not prescribed by the physician:

Ministry of Children, Community and Social Services

Service Delivery Division
CPRI
600 SANATORIUM ROAD
LONDON ON N6H 3W7
TEL: (519) 858-2774
FAX: (519) 858-3913
TTY: (519) 858-0257

Ministère des Services à l'enfance et des Services sociaux et communautaires

Division de la Prestation des Services
CPRI
600 CHEMIN SANATORIUM
LONDON ON N6H 3W7
TÉL: (519) 858-2774
TÉLÉC: (519) 858-3913
ATME: (519) 858-0257

Ontario

PART C

CB#_____

CONSENT TO THE DISCLOSURE, TRANSMITTAL OR EXAMINATION OF A CLINICAL RECORD

I,_____,_____, of _____
hereby authorize CPRI to examine/obtain from, transmit or
disclose to: **(Include full name/address of agency/school/physician)**

_____ _____
_____ _____
_____ _____

☐ Educational Records

☐ Clinical Records

in respect of _____ _____for the purpose of: Assessment, Treatment and Planning

Description of information to be examined/transmitted/disclosed:

☐ Any pertinent information

☐ Specifically: _____

Please note that this information may be released electronically, which includes by fax.

Unless otherwise stated, **this consent is valid for the length of time the child is receiving CPRI services and 1 year after all CPRI services are completed** (CPRI discharge) to allow:

- CPRI to assist you in your transition to other services as needed and/or,
- CPRI services to be re-activated within 1 year after your discharge when needed.

I understand that I may revoke this consent in writing at any time.

This consent for examination, transmittal or disclosure of information has been fully explained to me. I understand it and agree with the examination, transmittal or disclosure.

Child/Youth Signature _____ Date _____

And/Or ☐ Consent of substitute decision-maker is required.

Guardian/Substitute Decision-Maker Signature Date _____

_____

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Ontario

(SAMPLE)

CONSENT TO THE DISCLOSURE, TRANSMITTAL OR EXAMINATION OF A CLINICAL RECORD

I, Smith, Fred, of 600 Sanatorium Road London ON N6H 3W7 hereby authorize CPRI to examine/obtain from, transmit or disclose to: **(Include full name/address of agency/school/physician)**

Dr. John Brown 222 South St. Wood ON N6E 32C – Family Doctor
List Agencies & Address
Name of School & Address

the following: (check appropriate item(s))

☐ Educational Records

☐ Clinical Records

in respect of your child's name your child's date of birth
for the purpose of: Assessment, Treatment and Planning

Description of information to be examined/transmitted/disclosed:

☐ Any pertinent information

☐ Specifically:

Please note that this information may be released electronically, which includes by fax.

Unless otherwise stated, **this consent is valid for the length of time the child is receiving CPRI services and 1 year after all CPRI services are completed** (CPRI discharge) to allow:

- CPRI to assist you in your transition to other services as needed and/or,
- CPRI services to be re-activated within 1 year after your discharge when needed.

I understand that I may revoke this consent in writing at any time.

This consent for examination, transmittal or disclosure of information has been fully explained to me. I understand it and agree with the examination, transmittal or disclosure.

Child/Youth Signature Child/Youth Signature Date Date Signed

And/Or ☐ Consent of substitute decision-maker is required.

Guardian/Substitute Decision-Maker Signature Signature Date Date Signed

GUIDELINES FOR COMPLETION OF CONSENT TO THE DISCLOSURE, TRANSMITTAL OR EXAMINATION OF A CLINICAL RECORD FORM

1. Please specify if you wish to DISCLOSE or OBTAIN information.

2. To DISCLOSE information:

   - list as many agencies, facilities, physicians, paediatricians, etc. that are involved with the child/youth's care
   - be sure to include the complete mailing address, if available
   - reports will not automatically be sent unless specified by a verbal or written request from CPRI clinicians
   - dictated reports that have carbon copies (c.c.) will be mailed out by Clinical Records staff
   - CPRI requires a consent with an ORIGINAL SIGNATURE in order to release information

3. To OBTAIN information:
   - use a separate consent form for each request as agencies, facilities, physicians, paediatricians, etc. require an ORIGINAL consent
   - for ease in processing, we are using a separate consent to obtain/disclose information from/to school boards/schools
   - when requesting a child's birth record, it is helpful to include the mother's surname (if different than the child's or if different at the time of the birth) and mother's date of birth

*****IF YOU HAVE ANY QUESTIONS CONCERNING THE ABOVE, PLEASE CONTACT EXTENSION 2024*****

PART D

FREEDOM OF INFORMATION AND PROTECTION OF PRIVACY / PERSONAL HEALTH INFORMATION PROTECTION

NOTICE TO PARENTS

The Freedom of Information and Protection of Individual Privacy Act (FIPPA) and the Personal Health Information Protection Act (PHIPA) require that we tell you we will be collecting information about you and your child/youth as the result of their inquiry for service from CPRI. The authority to collect personal information comes from the Child, Youth and Family Services Act, which governs the services we provide to children/youth and families.

We collect information about indicated child/youth and family and treatment goals at every step of our involvement (including inquiry, referral, assessment and treatment). If we determine it is necessary to obtain reports from other community agencies or provide them with copies of our reports, we will obtain your written consent to do so. Once the indicated child/youth has been accepted as a referral, a casebook will be set up. The indicated child/youth's casebook will contain all information collected and reports written by members of your CPRI assessment/treatment team. Reports regarding the indicated child/youth's progress will be added as long as she/he continues to receive services through CPRI. You have the right to request access to these records at any time. CPRI will hold this information for at least 10 years past the indicated child/youth's 18th birthday.

CPRI uses some client information to review our services and do research about mental health. We do not use information that would identify your family. We only use information about groups. For example, of the clients we serve, 73% are boys and 27% are girls. We share non-identifying information with other organizations and in research presentations to help evaluate and improve mental health services for children and youth. CPRI will collect information on the indicated child/youth's sex and/or gender in order to support assessment and treatment planning.

This notice form is not a consent form. It is for your information only and need not be returned.

If you have any concerns or questions, please feel free to talk to a member of your CPRI team.

COMPLAINTS AND FEEDBACK

You have the right to make complaints about CPRI. Making a complaint will not impact the services you receive. You can make a complaint by speaking with any CPRI staff member or by contacting the Issues Manager at admin.CPRI@ontario.ca or 519-858- 2774 ext. 2011. To see the full process for making a complaint, visit www.cpri.ca/families/get-help or see the receptionist at Switchboard. You can also use a Caregiver 'Help Card' to talk with a CPRI staff member – these are found in the waiting room and around CPRI.