One Call, All Access for Child & Youth Mental Health

Access & System Navigation Form

Client Information:

First Name: _____ Last Name: _____

Date of Birth: _____ Gender: _____

Address: _____ City: _____

Postal Code: _____ Home Phone Number: _____

Cell Phone: _____ E-mail: _____

Preferred Communication Method: _____ **Should be where we can leave a secure message.**

Preferred Language: _____ ☐ Requires Interpreter:

Additional Service Considerations:

- ☐ D/deaf or Hard of Hearing
- ☐ Developmental Delays
- ☐ Sight Impairment
- ☐ Wheelchair Access Required
- ☐ Fetal Alcohol Spectrum Disorder - diagnosed or suspected

Family Physician Name: _____ Contact: _____

School & Child Care Information:

School or Child Care Centre Name: _____ Grade: _____

Name of primary staff contact (SERT, Principal, CYC, Resource Consultant): _____ Contact Info: _____

Does your child attend a Before and After School Program? Yes ☐ No ☐

Name of Before and After School Program: _____

Parent/Caregiver Information:

Parent/Caregiver Name (1):

Parent/Caregiver Name (2):

Date of Birth:

Date of Birth:

Address - same as above ☐

Address - same as above ☐

Address:

Address:

City:

City:

Postal Code:

Postal Code:

Home Phone:

Home Phone:

Cell Phone:

Cell Phone:

E-mail

E-mail

Preferred Communication Method:

Preferred Communication Method:

Primary Contact/Substitute Decision Maker:

Referral Information:

Referral Source:

☐ If Primary Care or Hospital, is the client being discharged from the Emergency Department or an Inpatient Unit.

Referral Agency Name:

Referral Contact Name:

Referral Contact Number:

Referral Contact E-mail:

Reason for Referral:

☐ Assessment
☐ Treatment
☐ Groups/Camps
☐ Resources/Information

Additional Referral Details:

☐ The child/youth at immediate risk of harm.

☐ The child/youth or a parent/guardian in the home at immediate risk of harm by the other parent/guardian.

☐ The child/youth has been involved with the police.

Referrals are made to Hamilton's Child and Youth Mental Health community-based system and ASN will support the navigation to the full list of service offerings with providers and clients.

The following programs listed below are direct referral programs for specific organizations. Please only select if you are referring specifically to one of these programs and are an approved referral source for the program as outlined below.

Direct Referral Programs:

☐ Child and Youth Mental Health Psychiatry Consultation (Physician Referrals Only)

☐ McMaster Hospital - Day Hospital Program (Physician Referrals Only - attach psychiatric assessment)

☐ Other (Please specify) _____

All referrals include a screening process to ensure that clients are connected to the most appropriate program or service based on an assessment of level of need and other inclusion and exclusion criteria. This screening should be done with the referring service provider(s), but can be completed by the caregiver or youth directly. If you have a strong understanding of the family/child/youth that you are referring, it is strongly suggested that you complete the screen with our ASN team. If you do not feel that you have enough information about the family/child/youth, then please indicate that you would like the ASN team to connect directly with the family:

☐ Please contact me (service provider) directly to conduct the screen.

☐ Please contact the caregiver(primary) to conduct the screen (you must notify the family that ASN will be calling)

☐ Please contact the youth to conduct the screen (you must notify the youth that ASN will be calling)

Consent to Obtain, Share and Disclose Information

Please ensure that you review and obtain consent from your client to the following:

• your information provided to support this referral will be placed in a shared database maintained by Lynwood Charlton Centre (LCC);

• LCC database is used by and between select youth mental health organizations for the purposes of making referrals and collaborating on care in a timely and secure manner. The participating organizations include Alternatives for Youth, Centre de sante communautaire Hamilton Niagara, Child and Adolescent Services, COAST, Good Shepherd, McMaster Child and Youth Mental Health Program and Woodview Mental Health and Autism Services;

• the information to be held in the database may include the following: client information (name, date of birth, address and contact information) and information about the programs and service provider name, appointment history, case notes and other documentation;

• the most up to date information about the LCC database can be found on LCC's web site at rockonline.ca; clients can connect directly with LCC's privacy officer at lwhittaker@lynwoodcharlton.ca .

☐ I have reviewed the information above with my client and have obtained their verbal consent to obtain, share and disclose this information with LCC.

Consent Obtained From: _____

Consent Obtained By: _____

Agency/Organization: _____

Date: _____

Authorized Communication Contacts

At the request and authorization of the client, LCC can use e-mail and text messaging, in addition to the phone, for communication to support the services the client may receive. The risks, limitations and conditions of use are available for clients to review on Lynwood Charlton Centre's website www.lynwoodcharlton.ca. Clients should be aware that e-mail and text messages are monitored within business hours and that we will respond in an as timely manner as possible. Please confirm with your client their authorized communication contacts:

Phone: _____

E-mail: _____

Text: _____

Please submit the completed form to the Access and System Navigation team through the Partner Portal or fax to: 905-389-8765.