Ontario

Ministry of Children, Community and Social Services

Child and Parent Resource Institute (CPRI)

Inpatient Referral Form

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

Services are provided through a short-term, inpatient 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

- ☐ Part A – Referral Information complete and signed
- ☐ Part B – Referral Information complete and signed by Attending Physician
- ☐ Part C – Education Information
- ☐ Part D – Consents and Reports complete and signed
  - ☐ Reports attached – Reports are reviewed to help understand a client's history and past services
    Please include reports to avoid delays in the referral process
  - ☐ If interpretation services are needed, complete and sign separate consent form provided.
    See sample and guidelines for important information.

Referral Form must include Parts A, B, C and D.

Please ensure you complete all pages of this form.

There is no page limit. You can add additional pages if more space is needed.

Completed packages or questions can be emailed to: CPRI.Intake@ontario.ca

Fax: 519-858-2115

Part A

Referrant Data

Single Point Access Agency Name

Current Community Case Manager/Service Coordinator For Child/Youth

Last Name	First Name

Agency

Mailing Address

Unit Number	Street Number	Street Name	PO Box

City/Town	Province	Postal Code

Email Address

Telephone Number	Cellular Number	Fax Number

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/Youth Data

Last Name	First Name

Preferred Name/Otherwise Known As

Date of Birth (yyyy/mm/dd)

Health Card Number (10 digits)	Version Code	Expiry Date (yyyy/mm/dd)

Sex ☐ Male ☐ Female

Gender Identity ☐ Male ☐ Female ☐ X

Interpreter Required ☐ Yes (See Section D for interpreter consent form) ☐ No

Languages Spoken

Languages Understood

Child/Youth Current Address

Unit Number	Street Number	Street Name	PO Box

City/Town	Province	Postal Code

Telephone Number

Living Arrangement

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)

☐ Yes (please specify) _____

☐ No

Parent/Legal Guardian 1

Last Name	First Name

Relationship to Child (e.g. mother, father, grandparent)

Current Address (if different from above)

Unit Number	Street Number	Street Name	PO Box

City/Town	Province	Postal Code

Email Address

Telephone Number	Cellular Number	Work Number

Has custody? ☐ Yes ☐ No

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

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

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

Parent/Legal Guardian 2

Last Name	First Name

Relationship to Child (e.g. mother, father, grandparent)

Current Address (if different from above)

Unit Number	Street Number	Street Name	PO Box

City/Town	Province	Postal Code

Email Address

Telephone Number	Cellular Number	Work Number

Has custody? ☐ Yes ☐ No

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

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
- ☐ Language
- ☐ Culture
- ☐ Religion
- ☐ Comment _____
- ☐ Physical Health
- ☐ Sexual Orientation
- ☐ First Nations
- ☐ Inuit
- ☐ Métis
- ☐ Identify as an Indigenous Person
- ☐ Other

Reason for Referral

If available, please attach referral information and approval from Access Mechanism and minutes from community table meeting.

Attached ☐ Yes ☐ No

Goals of Service (Please complete if not in access package)

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

High Risk Behaviours or Safety Concerns (Please complete if not in access package)

Describe in detail any high risk behaviour or safety concerns

Health Information

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

Hospital	Date (yyyy/mm/dd)	Reason (Mental Health and/or Physical Health Reason)

Family Physician

Last Name | First Name

Email Address

Telephone Number | Cellular Number | Fax Number

Paediatrician

Last Name | First Name

Email Address

Telephone Number | Cellular Number | Fax Number

Psychiatrist

Last Name | First Name

Email Address

Telephone Number | Cellular Number | Fax Number

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/supplements) **AND** any concerns for allergies to medications, food, tape, latex, environmental etc.:

Part B (Two pages to be completed and signed by the current community physician) - 1 of 2

Name of Child/Youth

Last Name	First Name

Date of Birth (yyyy/mm/dd)

Reason for 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 or pending
☐ MRI	
☐ EEG	
☐ Blood Work	
☐ Genetic Testing	
☐ ECG	
☐ Allergies (known)	
☐ Drug Allergies	
☐ Other (specify)	

Part B (Two pages to be completed and signed by the current community physician) - 2 of 2

Client Name

Last Name	First Name

Date of Birth (yyyy/mm/dd)

Referring Physician

Last Name	First Name

OHIP Billing Number

Address

Unit Number	Street Number	Street Name	PO Box

City/Town	Province	Postal Code

Email Address

Telephone Number	Cellular Number	Fax Number

Signature of Referring Physician	Date (yyyy/mm/dd)

Client's Primary Physician (if different from Referring Physician)

Last Name	First Name

Address

Unit Number	Street Number	Street Name	PO Box

City/Town	Province	Postal Code

Email Address

Telephone Number	Cellular Number	Fax Number

Additional and Relevant Background Information

Part C

Education

Community School

School Board

Grade

School Contact Information

School Contact (Last name, First name)

School Contact Number

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)

Part D

Past/Present Agency/Clinician Involvement: Please identify all agency involvement the child/family has had and attach all reports currently available (past and present and waitlist). **Please complete agency name and address if different from consent.**

Agency/Clinician	Past	Present	Waitlist	Report Attached	Agency Name/Address	Contact Person/ Phone Number
Children's Aid Society	☐	☐	☐	☐		
Children's Mental Health Agency	☐	☐	☐	☐		
Hospital mental health	☐	☐	☐	☐		
Hospital physical health	☐	☐	☐	☐		
Neurology	☐	☐	☐	☐		
Home/Respite Services	☐	☐	☐	☐		
Private Services	☐	☐	☐	☐		
Psychiatry	☐	☐	☐	☐		
Psychology	☐	☐	☐	☐		
Occupational Therapy	☐	☐	☐	☐		
Speech and Language	☐	☐	☐	☐		
Social Work	☐	☐	☐	☐		
Developmental Pediatrician	☐	☐	☐	☐		
Behaviour Services	☐	☐	☐	☐		
Medication profile from local pharmacy	☐	☐	☐	☐		
School Reports	☐	☐	☐	☐		
Other	☐	☐	☐	☐		
Other	☐	☐	☐	☐		

Ministry of Children, Community and Social Services (MCCSS)

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 (MSESC)

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

CB# _____

Consent to the Collection, Use or Disclosure of Personal Information or Personal Health Information

I, _____ , hereby authorize
(Print Name in Full of Client or Legal Guardian)

the Child and Parent Resource Institute (CPRI) to:

☑ Collect

☑ Use

☑ Disclose

the following information:

_____

_____

_____
(Specific Description of Information)

From:

_____ _____
(eg. Name of Referring Physician) (Address/Telephone)

_____ _____
(eg. Name of School) (Address/Telephone)

_____ _____
(eg. Name of Agency) (Address/Telephone)

_____ _____
(eg. Name) (Address/Telephone)

_____ _____
(eg. Name) (Address/Telephone)

From the records of:

_____ _____
(Full Name of Client) (Date of Birth (yyyy/mm/dd))

For the purpose of consenting to the collection, use or disclosure of personal health information.

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

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CPRI
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London ON N6H 3W7
Tél. : 519-858-2774
Téléc. : 519-858-3913
ATME : 519-858-0257

Ontario

CB# _____

If Translation or Interpetation is Required

Consent to the Collection, Use or Disclosure of Personal Information or Personal Health Information for Translation and Interpretation Services

I, _____ , hereby authorize
(Print Name in Full of Client or Legal Guardian)

the Child and Parent Resource Institute (CPRI) to:

☑ Collect

☑ Use

☑ Disclose

the following information:

_____

_____

_____
(Specific Description of Information)

From:

_____ _____
(eg. Name) (Address/Telephone)

_____ _____
(eg. Name) (Address/Telephone)

From the records of:

_____ _____
(Full Name of Client) (Date of Birth (yyyy/mm/dd))

For the purpose of consenting to the collection, use or disclosure of personal health information.

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

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Téléc. : 519-858-3913
ATME : 519-858-0257

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** (discharge from CPRI services) 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 if needed.

I understand that this consent may be terminated or changed at any time through a written request to CPRI Clinical Records Department. Withdrawal of consent is not retroactive to information already released.

This consent for collection or disclosure of personal information, including personal health information, has been fully explained to me.

Date (yyyy/mm/dd) _____ Child/Youth Signature _____

Or:

☐ Consent of Substitute Decision-Maker is required.

*NOTE: In accordance with PHIPA (*Personal Health Information Protection Act, 2004*) consent must be signed by the person to whom the information belongs or, if they are incapable, by their Substitute Decision Maker. A Substitute Decision Maker is a person authorized by PHIPA to consent on behalf of an individual, to collect or disclose personal health information about the individual.

Substitute Decision Maker's Name _____ Relationship to Client _____

Date (yyyy/mm/dd) _____ Substitute Decision Maker's Signature _____

Pursuant to s. 39 (1)(a) of the *Freedom of Information and Protection of Privacy Act* and s. 29 (a) of the *Personal Health Information Protection Act, 2004*, you are being asked to consent to CPRI's indirect collection, use or disclosure of your personal information, including personal health information, from the above-noted people or organizations.

Should you have any questions about this collection, use or disclosure of information by CPRI, please contact CPRI's Privacy Lead, at 519-858-2774.

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Part D

Protection of Privacy of Your Information at CPRI

The *Freedom of Information and Protection of Privacy Act* (FIPPA) and the *Personal Health Information Protection Act, 2004* (PHIPA) require that we tell you we will be collecting, using and disclosing information about you as the result of your inquiry for service from CPRI. These pieces of legislation provide us the authority to collect, use and disclose personal health information.

We collect information about you, your family and your treatment goals at every step of our involvement (including inquiry, referral, assessment and treatment). If we determine it is necessary to collect reports from other community agencies or to provide them with copies of our reports, we will obtain your written consent to do so. Once your referral has been accepted, a casebook will be set up. Your casebook will contain all information collected from other community agencies, as well as reports written by members of your CPRI assessment/treatment team. Reports regarding your progress will be added to your casebook as long as you continue 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 your 18th birthday.

CPRI uses some client information to review our services and do research about mental health. In doing so, we do not use information that would identify you or 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 your 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 cpri.admin@ontario.ca or 519-858-2774 extension 2011. To see the full process for making a complaint, visit Make a complaint about Child and Parent Resource Institute Services | ontario.ca or see the receptionist at Switchboard. You can also use a client ‘Help Card’ or a caregiver ‘Help Card’ to talk with a CPRI staff member – these are found in the waiting room and around CPRI.