Policy & Procedure Manual

REFERRAL AND INTAKE PROCESS FOR ADULTS AND CHILDREN ACCESSING THE COMMUNITY RESOURCE TEAM - CRT-I-2

POLICY:

Developmental Services Ontario (D.S.O) is the Ministry of Children, Community & Social Services designated agency to facilitate new adult referrals for developmental services. People requiring clinical services of the Community Resource Team (CRT) will apply for services through the D.S.O. office. Only those people already open and active within CRT may apply directly to CRT if they require another clinical service. Children behaviour referrals are received by The Access Network. Coordinated Service Planning referrals for children are received by Children's Centre Thunder Bay. The children referrals are either faxed or sent via secure email to the Manager of CRT.

PURPOSE:

To ensure fair and equitable access to services.

To ensure a timely response to referrals received by the CRT with follow-up either from the Manager, a team member or a referral to a more appropriate service provider.

To offer an intake meeting to determine/confirm the services being requested and to gather information about the individual for purposes of clinical planning.

To gather statistical information for the purposes of funding for the Ministry of Children, Community and Social Services.

PROCEDURE:

1. Referrals are received in written form from D.S.O. either by secure email, Developmental Services Consolidated Information System (DSCIS), mail or fax and sent directly to the Manager of Community Services. Referrals for individuals who are already open and active with CRT are forwarded to the Manager of Community Services using the CRT Referral form (Appendix A). Referrals for child behaviour or Coordinated Service Planning are either faxed or sent by secure email to the Manager of Community Services.

2. The Manager of Community Services reviews all documentation submitted and determines if; further information is warranted from either DSO or other referral source and contact is made to obtain the information.

If the referral meets CRT criteria for services the Manager of Community Services or assigned employee initiates the intake process. This process is as follows:

1. A search in the Alliance Information Management System (AIMS) is completed to determine any past involvement. Past paper files are also searched to determine the same.

2. An AIMS file is either re-opened or opened to begin the electronic file. A hard copy file is also generated at this time.

3. The Manager of Community Services or assigned employee attempts to initiate contact with either the contact person named on the referral or the referred person directly, depending on direction stated in the referral. This contact is usually by telephone or email but can also be done via correspondence if phone or email contact is unsuccessful.

4. The Manager of Community Services or assigned employee will attempt to schedule an intake appointment as soon as possible. Intakes are generally updated if they are older than two years.

5. The intake meeting usually occurs with the referred person unless there is reason they can't be present at this meeting (e.g. illness, etc.) and any other pertinent individuals involved with the person (employee, family). Every effort is made to include the referred person in the intake process unless discussions would upset or cause undue stress.

6. At the time of intake, the Manager or assigned employee completes an intake document (Appendix B) which provides an overview of the person. This document is typed and uploaded into AIMS as part of the record. The Quality Assurance requirements are also reviewed with the individual outlining our current Mission Statement/ Philosophy, Abuse Policy, and Service Principles and Statement of Rights and Feedback Policy.

7. A consent form to receive services is signed at the time of intake by the person and/or guardian (Appendix C) and uploaded in AIMS with the hard copy remaining on file.

8. All referrals will be brought to the CRT team meetings for clinical discussion and decision on assignment or waiting list.

9. The CRT team will make recommendations regarding which disciplines need to be involved with the individual and/or their support team. Where possible, the assignment of the team member to the referral will be made at the time of the team meeting. Where this is not possible, the Manager of Community Services will place the name of the person on a waiting list for services. The waiting list is reviewed at every clinical team meeting to ensure regular review of people waiting for service.

10. The Manager of Community Services or assigned employee will follow-up with the referral contact person and/or the person to advise of the outcome of the meeting and indicate the name of the team member assigned or the waiting list status.

11. The Manager of Community Services or assigned employee is responsible for the documentation on the AIMS and hard file until it is assigned to a clinician. Once a clinician is assigned, the clinician would document their contact with the person or alternate contact people in AIMS, Service Activities and will complete the AIMS Time Spent section.

12. While CRT is not considered a crisis response team, there may be referrals that require more immediate attention. These may include but are not limited to, wound care, catheterization, training on medical procedures, or behavioural concerns. These referrals still require intake through D.S.O. however, the Manager of Community Services may exercise discretion to assign a clinician before the formal team process should the situation warrant immediate attention. The referral will be reviewed more formally at the next scheduled team meeting.

13. The Manager of Community Services in conjunction with the Manager of Finance, will provide statistical information as required by the MCCSS.

14. For adults receiving behavioural services through our partnership with Thunder Bay Regional Health Sciences Centre (TBRHSC) Forensic Unit people will be assigned by the Manager of the Forensic Unit. Documentation will be completed as per direction of the Manager of Forensic. OPTIONS NORTHWEST will not keep an AIMS or paper records pertaining to the people we support in the TBRHSC - Forensic partnership role.

RECOMMENDED BY: Community Resource Team **APPENDICES:** 3

OPERATIONAL ACCOUNTABILITY: Community Resource Team, Administration, Community Services Administration

ORIGINAL POLICY DATE: July 2007

AUTHORIZED BY: Executive Director **SIGNATURE:** 

Policy: CRT-I-2
Appendix A

COMMUNITY RESOURCE TEAM (CRT)
OPTIONS NORTHWEST

95 Cumberland Street North
Thunder Bay, ON P7A 4M1
Phone: 344-4994 Fax: 346-5811

REFERRAL FORM

Name:	D.O.B.: (dd/mm/yyyy)	Male ☐ Female ☐
Address:		Postal Code:
Telephone Number (Home):		Business:

Contact Person:	Relationship:
Telephone Number:	Is individual aware of referral? Yes ☐ No ☐
Emergency Contact:	**Phone:**

Client Information	**Please indicate: Yes**	**No**	**Please list specifics**
Developmental Disability			
Mental Health Issues			
Exceptional Problematic Behaviour			
Medical Condition(s)			
Psychological Issues			
Substitute Decision Maker			
Has accessed OPTIONS NORTHWEST Community Resource Team before:			

Other Pertinent Information:

Service requested:

Health Care ☐	Behaviour Intervention ☐	Psychology ☐	Social Work ☐
Occupational Therapy ☐	Speech & Language ☐	Other ☐	

Other:

Reason for Referral (please be specific):

Name of Referring Agent:_____ Signature:_____

Date: Team Leader/Supervisor Signature:

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APPENDIX B

COMMUNITY RESOURCE TEAM
INTAKE FORM

Name of Individual Referred: _____ ☐ Male ☐ Female

Date of Interview: _____

Date of Update: _____

Names of those participating in this intake: _____

Decision Making (SDM, POA): _____

Birth Date *(Month/Day/Year):*		Age:	
Street Address:			
City:		Postal Code:	
Telephone:		Health Card Number:	

Diagnosis of Individual: _____

Present Living Conditions: ☐ Independent ☐ Group Home ☐ Family Home

☐ Lives at home with family ☐ Other: _____

Services the Individual presently receives or has in the past. Indicate date if known (check off):

	Present	Past
Vocational/Employment Services		
Counseling		
Respite		
Adult Protective Services Worker		
Special Service Coordinator		
Psychological Services		
Mental Health Services		
Psychiatric Services		
Occupational Therapy		
Speech – Language Services		
Physiotherapy		
Spiritual		
Developmental Services		
Social Work Services		
Health (VON etc.)		
Chiropodist		
Foot care nurse		
Nutritionist		
March of Dimes		
ODSP/Other Income		
North Network of Specialized Care		
Special Olympics		
Passport		

REFERRAL INFORMATION

Who referred the Individual:

1) **Why was the individual referred?**

DSO initiated Referral: **Yes ☐** **No ☐**

If No – Referral Source:

2) **What is presenting the issue:**

REFERRAL INFORMATION (cont'd)

3) Contributing Factors (What events seem to trigger the issue):

4) What steps have been taken to address the referral issue:

BACKGROUND INFORMATION

MEDICAL HISTORY:

Physician:	Dentist:	Specialist:

1) Has this individual been hospitalized in the last 2 years, if yes, for what:

2) Check all conditions that apply to the individual:

☐ Hypertension (high blood pressure)	☐ Asthma	☐ (Pre)Diabetes
☐ Lung (respiratory problems)	☐ Epilepsy	☐ Head/brain Injury
☐ Speech/Language problem	☐ Polio	☐ Hyperactivity
☐ Vision problem (i.e. Cataracts)	☐ Hearing problem	☐ Arthritis
☐ Heart disease or defect	☐ Sleep disorder	☐ Cerebral Palsy
☐ Postural deformities (e.g. Scoliosis)		
☐ Other:		

3) ☐ Mental/Psychiatric Illness (list if known):

☐ Emotional Issues (physical /sexual assault)

4) *** Allergies (list all):**

5) **List all current prescription and over-the-counter medications (include PRN's):**

Medication	*Dosage*	*How many times a day*

6) **Have there been any recent changes in medication (in the last 6 months)?**

7) **List all current treatments (e.g. ointments, suppositories, inhalers, etc.):**

8) **Does the individual use any assistive devices:**

- ☐ Mobility (e.g. wheelchair, walker)
- ☐ Hearing (e.g. hearing aid)
- ☐ Communication (e.g. picture board, voice amplifier)
- ☐ Eyesight (e.g. eye glasses, cane)
- ☐ Orthotic devices (e.g. splints, safety bars)
- ☐ No Assistive Devices
- ☐ Other

COMMUNICATION

1) **Has this individual ever been referred to a speech language pathologist or an augmentative program?**

☐ Yes ☐ No Where:

2) **Present Communication Styles:**

☐ Sign Language ☐ Speech ☐ Picture Display ☐ Gestures

☐ Other (please specify): _____

3) **If the individual has speech, please indicate to what extent:**

☐ one word ☐ two words ☐ Incomplete Sentences ☐ Complete Sentences

4) **Can you understand the individual's speech?**

☐ No ☐ Sometimes ☐ All the time

5) **Is the individual** ☐ right handed or ☐ left handed

6) **Gross Motor Skills** ☐ Poor ☐ Fair ☐ Good ☐ Very Good

Fine Motor Skills ☐ Poor ☐ Fair ☐ Good ☐ Very Good

7) **Can the individual independently** ☐ read ☐ write ☐ print

To What Level?

8) **Is the Individual able to:**

Dress Self:

Shower/bath Self:

Personal Hygiene Routines:

How much care is needed or just reminders?

EDUCATION

1)

SCHOOLS ATTENDED	AGE COMPLETED	REASON FOR LEAVING
1)		
2)		
3)		
4)		

EMPLOYMENT

1) **Check off which applies:** ☐ Currently not employed ☐ Full time job ☐ Part time ☐ Volunteer work ☐ Paid work ☐ Unpaid work

2) **Describe the individual's last three jobs (start with most recent):**

Job Title	*Responsibilities*	*Time Employed*	*Why did they leave?*

3) **Does the Individual enjoy their work/activity?**

If not working/volunteering, would they like to and what would they like to do?

LIFESTYLE FACTORS

1) **Describe diet and eating Habits:**

Any Special Diet?

Does Individual help cook meals/buy groceries?

Can she/he use a stove/microwave?

2) **Describe the individual's sleep patterns.**

Sleep at night?

LIFESTYLE FACTORS (cont'd)

3) **Does the individual get exercise? If yes, how?**

4) **Does the individual** ☐ Smoke ☐ Use recreational drugs ☐ Drink alcohol

LEISURE ACTIVITIES

What does the Individual enjoy doing?

1) **Describe the individual's social relationships in the community and at home (e.g. friends, acquaintances, volunteers) and how they react with others.**

2) **Does the individual have a hobby or interest in the community or at home (e.g. collecting teddy bears/hockey cards, art or dance)?**

FAMILY HISTORY

		AGE
Mother/Guardian/Foster Mom's Name:		
Father/Guardian/Foster Dad's Name:		
Brother(s) Sister(s):		
Extended Family:		

FAMILY HISTORY (cont'd)

1) **Are you aware of any family history of medical illnesses (e.g. migraines, diabetes, etc.)?**

2) **Are you aware of any family history of mental health issues within the family (e.g. schizophrenia, etc.)**

3) **Describe the nature of family relationships.**

Any additional Comments:

Urgency of Referral:

- **Crisis** ☐
- **Urgent** ☐
- **Non-Urgent** ☐

Intake Completed by: _____ Dated: _____

COMMUNITY RESOURCE TEAM
Intake form – (for CRT use only)

Name of Individual: _____

Urgency of Referral:

☐ **CRISIS**

☐ **URGENT**

☐ **NON-URGENT**

Date intake presented at CRT meeting: _____

ACTION TAKEN BY TEAM:

WAITING LIST:

Initial Assignment of Case:

Name of Service Provider	Type of Service (s)	What will be provided

Comments:

Signature CRT Manager: _____

Date: _____

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APPENDIX C

- OPTIONS northwest -
95 Cumberland Street N, Thunder Bay, ON P7A 4M1
Phone: 344-4994 Fax: 346-5811

COMMUNITY RESOURCE TEAM

I, _____, hereby consent to _____
(Client, Parent, Next of Kin, Legal Guardian) (Name of Client) *Please Print*

receiving services from the Community Resource Team & students working with CRT for the following:

_____

_____

_____

I understand that my consent for the above and participation in the same are voluntary.

This consent is valid up to the expiry date indicated below:

EXPIRY DATE: _____

Signature: _____ **Witness' Signature:** _____

Date: _____

Consent for the purposes of this form may be signed by clients, 16 years of age or older, if they have the "Capacity" to give consent.

"Capacity" for the purposes of this form is defined as having the ability to understand and appreciate the nature of consent and the consequences of giving, withholding or revoking consent.