F.W. SCHUMACHER
LIVE-IN TREATMENT PROGRAM REFERRAL FORM

North Eastern Ontario
Family and Children's Services
Services à la famille et à l'enfance
du Nord-Est de l'Ontario

Return to:

F.W. Schumacher
68 Aura Lake Road
P.O. Box 850
Schumacher Ontario
P0N 1G0
Telephone: (705) 360-7230
Fax: (705) 264-5888
Email: TimminsClericalMH@neofacs.org

Attention: Laurent Gilbert, Program Supervisor

The F.W. Schumacher live-in treatment program is an 8-bed bilingual mental health treatment program for children and youth ages 12-15.

The admissions committee is comprised of the following representatives:

- Service Manager, Program Supervisor,
- Shift Supervisors,
- Representative of Counselling and Therapy Services,
- Representative from Resource Program, and
- Representative from French and English School Board (Mental Health Leads).

The program requires the commitment of the client and their parent(s)/legal guardians for a minimum 6 month stay with the possibility of an extension pending the review process at the Case Management meetings.

Extensions are requested in writing to the Program Supervisor.

Furthermore, the program requires a commitment from both the client and the parent(s)/legal guardian(s) to attend all monthly case management meetings, be actively involved in the planning of home visits, and attend weekly counselling sessions with the assigned clinician from our Counselling and Therapy Services Program.

REFERRAL PROCEDURE FOR F.W. SCHUMACHER

1. Agency staff and /or parent(s) / legal guardian(s) completes the referral form. This request will include the following documentation (when possible):
   - Social and family history
   - Psychological assessment
   - Psychiatric assessment
   - School reports
   - Reports from other services involved
   - Any other document that is pertinent for this referral

2. The referral will be sent or mailed to the address provided above.

3. The Admission Committee meets monthly to evaluate all referrals for admissions to the program. The worker or parent(s)/legal guardian(s) may be asked to attend this meeting or participate by phone or TEAMS to provide recent updates on the situation and answer any questions we may have.

4. Should the referral be incomplete, the Program Supervisor will contact the referral source for additional information. Missing information and/or reports should be re-submitted as soon as possible to ensure that a decision is made in a timely manner.

5. The Program Supervisor is responsible for confirming the Committee's decision to the referral source by telephone and/or writing within 3 business days and establishing pre-placement and admission dates to the program.

   If you have any questions or need more information, please do not hesitate to communicate with the Program Supervisor.

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F.W. Schumacher
Live-in Treatment Program Referral Form

Section A: Referral Information	
Referral date:	
Referring agency: *(if applicable)*	
Name of person completing referral:	
Address:	
Telephone:	Extension:

Section B: Client Information			
Name of Client:	Alias/Known As:		EMHware File Number:
Date of Birth :	Gender:		
DD MM YY			
Address/City/Prov/Postal Code/Box #:	Telephone Numbers:		Worker can call #:
	Home:		☐Yes ☐No
	Cell:		☐Yes ☐No
	Email:		☐Yes ☐No
	Other:		☐Yes ☐No
School/ Grade:			
Ethnic Origin/First Nation:			
Language:	☐English ☐French ☐Other:		
Religion:			
Does the client wish to receive religious instruction while in care:	☐ Yes ☐ No		
Client living with: *(Name of Person)*			
Relationship to client:			
Address:			
Telephone:	Home:		Work:

Section C: Legal Guardian *(if different from above)*

☐ Birth Parent(s)
☐ Adoptive Parent(s)
☐ CAS Non-Ward
☐ Extended Society Care
☐ Interim Society Care
☐ Joint Custody Agreement

	Parent	Parent	Other
Name			
D.O.B./ (day/month/year)			
Maiden name /last name			
Address			
City			
Province			
Postal Code			
Home phone			
Work Phone			
Language(s) spoken			
Income Source			

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

Name	Relationship to client	Age	Gender	Lives at home	Employment or School Year
			☐ F ☐ M ☐ Other	☐ Yes ☐ No	☐Employment ☐School
			☐ F ☐ M ☐ Other	☐ Yes ☐ No	☐Employment ☐School
			☐ F ☐ M ☐ Other	☐ Yes ☐ No	☐Employment ☐School
			☐ F ☐ M ☐ Other	☐ Yes ☐ No	☐Employment ☐School
			☐ F ☐ M ☐ Other	☐ Yes ☐ No	☐Employment ☐School
			☐ F ☐ M ☐ Other	☐ Yes ☐ No	☐Employment ☐School

Section D: Identified Family Problems

Situation	Yes	No	Who?
Alcohol misuse	☐	☐	_____
Drug misuse	☐	☐	_____
Conflict with the law	☐	☐	_____
Domestic violence	☐	☐	_____
Psychiatric diagnostic	☐	☐	_____
Psychological diagnostic	☐	☐	_____
Suicidal attempt/ideation/threats	☐	☐	_____
Self Harm	☐	☐	_____
Other: _____	☐	☐	_____

Family History and Functioning:

Additional family information (*history of mental health diagnosis, health issues, etc, in the family)*

Section E: Family Genogram

Section F: Education Information

School currently enrolled:	
Is the client currently attending school:	☐ yes ☐ no
Town/City:	
Grade level:	
Level of success:	☐ low ☐ average ☐ high
Are there academic concerns or needs?	☐ yes ☐ no

Year	School	Regular or special program	Comments
		☐ regular ☐ special	
		☐ regular ☐ special	
		☐ regular ☐ special	
		☐ regular ☐ special	
		☐ regular ☐ special	

Other educational information not mentioned in this referral

Section G: Health Information

Health card number:	
Insurance and drug plan name and number:	
Name of Physician:	
Address:	
Phone number:	
Date of last medical exam:	. . Day/Month/Year
Are there medical concerns/limitations:	
Does the client have allergies?	
Does the client require an EpiPen?	☐ yes ☐ no
Name of Dentist:	
Address:	

Phone number:	
Date of last dental exam:	. . Day/Month/Year
Are there dental concerns:	
Name of Optometrist:	
Address:	
Phone number:	
Date of last optical exam:	. . Day/Month/Year
Are there dental concerns:	

Section H: Reasons for referral: (Please outline present issues, concerns, needs, in regard to behaviours, mental health, health, emotional concerns)

Reason for referral and presenting needs

PRESENTING ISSUES - ONLY CHOOSE 3

- ☐ Abuse
- ☐ Adjustment problems
- ☐ Adoption issues
- ☐ Aggressive behavior
- ☐ Anger management
- ☐ Anti-social behavior
- ☐ Anxiety issues
- ☐ Attachment issues
- ☐ Attention/concentration/ hyperactivity
- ☐ Autism spectrum disorder
- ☐ Bullying
- ☐ Case management
- ☐ Child management issues
- ☐ Cruelty to animals
- ☐ Defies authority
- ☐ Depression
- ☐ Dishonesty
- ☐ Eating behaviour issues
- ☐ Emotion regulation/Mood fluctuations
- ☐ Encopresis
- ☐ Enuresis
- ☐ Family violence/conflict
- ☐ File Disclosure
- ☐ Fire setting
- ☐ Gender identity issues
- ☐ Homicidal ideations/threat
- ☐ Life skills
- ☐ Loss and grief
- ☐ Medical concerns
- ☐ Oppositional defiant behaviours
- ☐ Parent-child conflict
- ☐ Parent mental health/substance use issues
- ☐ Parenting skills
- ☐ Relationship problems/abuse
- ☐ Running away issues
- ☐ School based issues: academic/ emotional/ behavioural/attendance
- ☐ Self-harming behaviours
- ☐ Self-esteem issues
- ☐ Sensory issues
- ☐ Separation/divorce/blended family issues
- ☐ Sexually inappropriate behaviours
- ☐ Sexual orientation issues
- ☐ Sibling issues
- ☐ Sleep issues
- ☐ Social skills issues
- ☐ Somatic complaints
- ☐ Stealing
- ☐ Substance use/misuse
- ☐ Suicide ideations/threat/ gestures/attempts
- ☐ Thought issues (hallucinations/delusions/ irrational thinking)
- ☐ Trauma
- ☐ Withdrawing/isolating behaviors

Desired change – Treatment objectives

Goals to achieve
Goal # 1: _____
Goal # 2: _____
Goal # 3: _____

Plan for client upon discharge from the program:

Who will attend the care meeting(s)? (parent(s)/legal guardian(s), worker(s), etc.)		
Name	**Relationship**	**Phone**

Section I: Difficulties 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 month)
2. **Current** (within the last six month)
3. **Both** past and current

A) Home – Family Circumstances

	P	C	B	Comments
1. Acting out	☐	☐	☐	
2. Relationship issues	☐	☐	☐	
3. Emotional issues	☐	☐	☐	
4. Significant separation from family	☐	☐	☐	
5. Death of a significant other	☐	☐	☐	
6. Family disruption (separation, etc.)	☐	☐	☐	
7. Family conflict	☐	☐	☐	
8. Domestic violence	☐	☐	☐	
9. Family alcoholism/substance misuse	☐	☐	☐	
10. Multiple moves	☐	☐	☐	
11. Financial stress	☐	☐	☐	
12. Family health illness/injury	☐	☐	☐	
13. Family psychiatric issues	☐	☐	☐	
14. Family legal issues	☐	☐	☐	
15. Family involvement with multiple community agencies	☐	☐	☐	

B) School – Education

	P	C	B	Comments
1. Acting out	☐	☐	☐	
2. Relationship issues	☐	☐	☐	
3. Emotional issues	☐	☐	☐	
4. School underachievement	☐	☐	☐	
5. Diagnosed learning difficulties	☐	☐	☐	

C) Behaviour - Traits

	P	C	B	Comments
1. Inappropriate sexual behaviour	☐	☐	☐	
2. Refusing help	☐	☐	☐	
3. Alcohol/substance misuse	☐	☐	☐	
4. Oppositional/defiant	☐	☐	☐	
5. Aggressive	☐	☐	☐	
6. Temper tantrums	☐	☐	☐	
7. Physical/sensory diagnoses/needs	☐	☐	☐	
8. Significant physical illness/injury	☐	☐	☐	
9. Fire setting	☐	☐	☐	
10. Vandalism	☐	☐	☐	
11. Theft	☐	☐	☐	

D) Community

	P	C	B	Comments
1. Acting out	☐	☐	☐	_____
2. Relationship issues	☐	☐	☐	_____
3. Emotional issues	☐	☐	☐	_____

E) Peer Relations

	P	C	B	Comments
1. Relationship issues	☐	☐	☐	_____
2. Some negative peer influence	☐	☐	☐	_____
3. Change in peer groups	☐	☐	☐	_____

F) Symptoms/Diagnosis

	P	C	B	Comments
1. Nightmare or panic attacks	☐	☐	☐	_____
2. Somatising	☐	☐	☐	_____
3. Enuresis or Encopresis	☐	☐	☐	_____
4. Hyperactive	☐	☐	☐	_____
5. Delusional thinking	☐	☐	☐	_____
6. Eating disorder	☐	☐	☐	_____
7. Psychiatric issues	☐	☐	☐	_____

G) Aggressive and high-risk behavior

	P	C	B	Comments
1. Destructive	☐	☐	☐	_____
2. Sexually assaultive behaviour	☐	☐	☐	_____
3. Behaviour towards authority figures	☐	☐	☐	_____
4. Incident involving use of weapons	☐	☐	☐	_____
5. Suicidal attempts – ideations/threats	☐	☐	☐	_____
6. Self-harm	☐	☐	☐	_____
7. Running away	☐	☐	☐	_____

Difficulties Checklist completed by:	
Name:	Date:

Section J: Supporting and monitoring services					
Name of Agency	Type of Service	Presently involved	Duration	Name of worker	Outcome
		☐ yes ☐ no			
		☐ yes ☐ no			
		☐ yes ☐ no			
		☐ yes ☐ no			
		☐ yes ☐ no			
		☐ yes ☐ no			

Section K: Assessment			
Type of assessment	Date (s)	Agency	Copy provided with this referral
			☐ yes ☐ no
			☐ yes ☐ no
			☐ yes ☐ no
			☐ yes ☐ no

PLEASE INCLUDE ALL REPORTS AVAILABLE WITH THIS REFERRAL

Section L: Out of home placement			
Type of placement	Duration	Reason for placement	Outcome

Signature	
Completed by:	Date:
Signature of Program Supervisor or Service Manager:	Date:

***If a parent(s)/legal guardian(s) is/are referring, no program supervisor or service manager's signature is required.**

IMPORTANT (BEFORE YOU SUBMIT THE REFERRAL, PLEASE ENSURE TO COMPLETE THE FOLLOWING:

☐ Ensure to complete this referral form in full to ensure the committee has all of the information that they require to make the most informed decision and to avoid having the form returned to you.

☐ Ensure the medical examination form attached is completed by the client's medical Practitioner, prior to admission.

☐ Attach photocopies of the most recent dental, optical and hearing exams.

☐ Attach a photocopy of the most recent Immunization record.

☐ Attach a photocopy of the client's health card.

☐ If the client is currently on a prescribed medication, please ensure a 30-day supply of medication is brought with you on the day of admission. All medication must be in properly labelled prescription bottles and when possible, in blister/bubble packs.

☐ Attach a Consent for Disclosure PHIPA duly completed and signed by the client.

NOTE: The referral will be processed **only if** the consent is complete and signed **or if** there is an explanation below as to why the consent is not signed (i.e., verbal consent was obtained by the client, or the client was assessed by the worker completing the referral and deemed being incapable of consenting/explain what are the barriers / etc.)

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CLIENT ADMISSION MEDICAL REPORT
F.W. SCHUMACHER LIVE-IN TREATMENT PROGRAM

SECTION A: CLIENT INFORMATION	
Name of Client:	
Date of Birth:	Day/Month/Year
Date of Examination:	
Reason for delay: (If not within 72hrs)	
Health Card Number:	

Current Medication: (Psychotropic, Prescribed, Non-Prescribed, Birth Control, etc.)	Medication	Dosage	Frequency

SECTION B: MEDICAL HISTORY OF CLIENT	
Previous illness/diseases:	
Previous surgeries:	
Hospitalized within last year?	
Known allergies:	
Other:	

SECTION C: TO BE COMPLETED BY PHYSICIAN			
Eyes: Include Vision	☐	Abdomen:	☐
Ears: Include Hearing	☐	Posture:	☐
Nose:	☐	Skin:	☐
Throat:	☐	Hemoglobin:	☐
Teeth:	☐	Urinalysis:	☐
Glands:	☐	Heart:	☐
Chest:	☐	Blood Pressure:	☐
Height:			
Weight:			

Results of Examination:	Exam normal ☐ Follow up required ☐ Comments:

SECTION D: PHYSICAL RECREATION ACTIVITIES	
A-Unlimited:	☐
B- Non-Competitive:	☐
C- Unrestricted:	☐
D- Exempt:	☐

SECTION E: PHYSICIAN'S COMMENTS

Signature of Physician:	Date

DISTRIBUTION	
Original:	
Copy(ies):	

LIST OF ITEMS REQUIRED AT ADMISSION
F.W. SCHUMACHER

The F.W. Schumacher personnel recommends the following items at admission:

- ✓ 5-7 pairs of pants
- ✓ 5-7 T-shirts and/or 5 sweaters
- ✓ 5-7 pairs of underwear
- ✓ 5-7 pairs of socks
- ✓ 2-3 pyjamas
- ✓ 2 bathing suits/swim-shorts
- ✓ Seasonal: - snowsuit, boots, toque, mitts
- ✓ Seasonal: - sandals, hat, sunglasses
- ✓ outdoor footwear and indoor footwear
- ✓ slippers
- ✓ No electronic recordable/picture/video devices permitted (i.e., MP3, games systems, IPOD, etc.)
- ✓ No glass objects
- ✓ personal bedding optional
- ✓ personal pictures, stuffed animals, religious and cultural items

Hygiene Products:

- ✓ 2 toothbrushes
- ✓ 2 tubes of toothpaste
- ✓ 2 bottles of shampoo/conditioner
- ✓ 2 pack of soap or extra body washes
- ✓ 1 small make-up bag
- ✓ No perfumes/cologne/body sprays (We are a scent free environment)
- ✓ 2 boxes of feminine products
- ✓ 2 deodorants

Please do not bring more than what is required on the list.

Should you have questions, please call 1-705-360-7230.