THE CHILDREN'S FOUNDATION
HEARTWOOD HOUSE
CHILD ASSESSMENT TEAM (CAT)
2750 East 18th Ave.
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## SECTION I - REFERRAL INFORMATION

| DATE FORM COMPLETED: | NAME OF PERSON REFERRING CHILD: | RELATIONSHIP TO CHILD: | REFERRING AGENCY (e.g., MCFD): |
|---|---|---|---|
| REFERRER'S MAILING ADDRESS (street, city, province, postal code): | | REFERRER'S TELEPHONE: | REFERRER'S EMAIL: |

TYPE OF ASSESSMENT REQUESTED: **NOTE: Only psychology and pediatric CDBC assessments available at this time.*

☐ Complex Developmental & Behavioural Conditions (CDBC) *(includes psychology and/or pediatric CDBC assessment)*

PAYMENT (e.g., paid by The Children's Foundation, referring agency, family, extended health insurance):

PLEASE SPECIFY ALL PERSONS TO PARTICIPATE IN THIS ASSESSMENT WITH THE CHILD (e.g., legal guardian, foster parent, birth parent, TCF therapist):

PLEASE SPECIFY ALL PERSONS TO RECEIVE COPIES OF COMPLETED ASSESSMENT REPORTS (e.g., legal guardian, foster parent, birth parent, TCF therapist, referring doctor, school resource teacher, CYMH counselor):

## SECTION II – CHILD AND FAMILY INFORMATION

| CHILD'S LEGAL NAME IN FULL: | KNOWN AS: | DATE OF BIRTH: | GENDER: | PERSONAL HEALTH / CARECARD #: |
|---|---|---|---|---|
| CHILD'S PRIMARY LANGUAGE(S): | | CHILD'S ETHNIC BACKGROUND (IF CHILD HAS ABORIGINAL ETHNIC BACKGROUND, PLEASE SPECIFY IF FIRST NATIONS / MÉTIS / INUIT AND BAND / TRIBE): | | |
| CHILD'S LEGAL GUARDIAN(S): | LEGAL STATUS (CCO, YA): | EXPIRY OF LEGAL STATUS: | | DATE OF NEXT COURT HEARING/REVIEW: |
| LEGAL GUARDIAN'S MAILING ADDRESS (street, city, province, postal code): | | LEGAL GUARDIAN'S PHONE: | | LEGAL GUARDIAN'S EMAIL: |
| PRIMARY CAREGIVER(S) (NAME OF PERSON(S) CHILD LIVES WITH): | | RELATIONSHIP TO CHILD: | | CHILD IN THEIR CARE SINCE WHAT DATE: |
| CAREGIVER'S MAILING ADDRESS (street, city, province, postal code): | | CAREGIVER'S PHONE: | | CAREGIVER'S EMAIL: |
| WHAT LANGUAGE(S) ARE SPOKEN AT HOME? | | DO PRIMARY CAREGIVER(S) REQUIRE AN INTERPRETER? | | |
| BIRTH MOTHER (IF DIFFERENT FROM PRIMARY CAREGIVER): | | DOES CHILD HAVE CONTACT WITH MOTHER? PLEASE SPECIFY: | | |
| BIRTH FATHER (IF DIFFERENT FROM PRIMARY CAREGIVER): | | DOES CHILD HAVE CONTACT WITH FATHER? PLEASE SPECIFY: | | |

| OTHER FAMILY MEMBERS AND SIGNIFICANT ADULTS IN CHILD'S LIFE (e.g., siblings, grandparents): | | | | |
|---|---|---|---|---|
| NAME: | RELATIONSHIP TO CHILD: | LIVING W/ THE CHILD? | AGE: | OTHER RELEVANT INFORMATION: |
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| PREVIOUS CAREGIVER(S) / PLACEMENTS: | | | |
|---|---|---|---|
| NAME: | RELATIONSHIP TO CHILD: | DATES CHILD IN THEIR CARE: | REASON FOR CHANGE OF PLACEMENT: |
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## SECTION III – EDUCATION INFORMATION

| SCHOOL NAME: | SCHOOL MAILING ADDRESS (street, city, province, postal code): | SCHOOL PHONE: |
|---|---|---|
| TYPE OF CLASSROOM SETTING/PROGRAM: | SPECIAL NEEDS DESIGNATION: | CURRENT GRADE: |
| SUPPORTS IN PLACE (e.g., IEP, aide, learning assistance, counseling support, Aboriginal worker): | OTHER PERTINENT INFORMATION REGARDING SCHOOL: | MEDICAL EXCLUSION IN PLACE? |
| SCHOOL TEAM MEMBERS INVOLVED: | ROLE: | PHONE/EMAIL: |
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## SECTION IV – REASONS FOR REFERRAL

**GIVE A BRIEF DESCRIPTION OF THE REASON FOR THIS REFERRAL:**

**IS THERE CONCERN OF PRENATAL ALCOHOL / SUBSTANCE EXPOSURE? IF YES, PLEASE SPECIFY (e.g., confirmed by birth mother / in birth records / by reliable witness; specify time of exposure such as first six weeks before mother knew she was pregnant; specific type of substance and quantity if known):**

**IS THERE CONCERN OF COMPLEX CHILDHOOD TRAUMA? IF YES, PLEASE SPECIFY (e.g., current/past family stressors and concerns, neglect, physical/emotional/sexual abuse, witness/victim of domestic violence, parental mental illness/addictions/incarceration, disrupted attachments; specify dates if known):**

| **STRENGTHS**<br>PLEASE LIST THIS CHILD'S STRENGTHS: | **NEEDS / CONCERNS**<br>PLEASE LIST ANY NEEDS/CONCERNS REGARDING THIS CHILD THAT APPLY: |
|---|---|
| | **Learning difficulties:** |
| | **Language/communication difficulties:** |
| | **Physical/motor difficulties:** |
| | **Attention difficulties:** |
| | **Executive function difficulties (e.g., planning):** |
| | **Adaptive functioning / daily living difficulties:** |
| | **Social difficulties:** |
| | **Behaviour difficulties:** |
| | **Emotional difficulties:** |

## SECTION V – PHYSICAL & MENTAL HEALTH INFORMATION

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|---|---|---|
| **CHILD'S FAMILY DOCTOR (GP):** | **PHONE:** | **FAX:** |
| **CHILD'S SPECIALIST (e.g. pediatrician): (PLEASE SPECIFY)** | **PHONE:** | **FAX:** |
| **OTHER PHYSICIAN / MEDICAL / MENTAL HEALTH TEAM (e.g, psychiatrist, CYMH):** | **PHONE:** | **FAX:** |
| **OTHER PHYSICIAN / MEDICAL / MENTAL HEALTH TEAM (e.g, psychiatrist, CYMH):** | **PHONE:** | **FAX:** |
| **OTHER PHYSICIAN / MEDICAL / MENTAL HEALTH TEAM (e.g, psychiatrist, CYMH):** | **PHONE:** | **FAX:** |

**PHYSICAL & MENTAL HEALTH CONCERNS:**

**CURRENT MEDICATIONS:**

**CURRENT SAFETY CONCERNS (e.g., at risk of aggression/violent behavior? self-harm? flight risk?)**

| **ANY FORMAL DIAGNOSES:** | **DIAGNOSIS GIVEN BY:** |
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## SECTION VI – BACKGROUND INFORMATION

**RELEVANT FAMILY HISTORY (e.g., parental history of learning difficulties, extended family member with Autism Spectrum Disorder):**

**RELEVANT PREGNANCY AND BIRTH HISTORY (e.g., gestational diabetes, high stress during the pregnancy, prenatal alcohol / substance exposure, prematurity, complications at birth, neonatal illness):**

**RELEVANT DEVELOPMENTAL HISTORY (e.g., global developmental delay, speech and language delay, gross/fine motor delay):**

**PLEASE LIST ANY PREVIOUS ASSESSMENTS (e.g., Sunny Hill Health Centre or Asante Centre CDBC assessment, school psychoeducational assessment, Maples / Youth Forensic Psychiatric Services assessment, SLP / OT / PT assessment, CYMH / Psychiatric assessment) AND ATTACH REPORTS TO THIS REFERRAL FORM:**

| **ASSESSMENT TYPE:** | **ASSESSMENT DATE:** |
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**Please forward this referral to the Heartwood House Child Assessment Team (CAT) for initial screening. We will contact you when the referral has been reviewed.**

**THANK YOU!**