Centre intégré
de santé
et de services sociaux
de la Montérégie-Ouest
Québec

Facility : _____

CLSC file : _____

Name, first name : _____

Date of birth : _____ ☐ F ☐ M
yyyy-mm-dd

Health insurance card # : _____ Exp: _____
yyyy-mm

Mother's name: _____

SERVICE REQUEST (YOUTH)

Referrer: Send all relevant reports with completed service request

CLIENT INFORMATION

Address :		Cell phone :
City :	ZIP code :	Email :
Name of parent 1 :		Home phone :
Address, if different of client :		Cell phone :
		Email :
Name of parent 2 :		Homephone :
Address, if different of client :		Cell phone :
		Email :
Guardian : ☐ Parent 1 ☐ Parent 2 ☐Other (specify):		Address, if different of client :
Name of family doctor:		Contact information :
Name of school or daycare :		Contact information :
Language: ☐ French ☐ English ☐ Other (specify):		

YOUTH PROTECTION

Is the youth monitored by Youth Protection[1] ☐ No	
If yes ☐ RTS[2] ☐ Assessment/Orientation ☐ Protective measures are applied	
The status of the request to the Youth Centres is : ☐ In follow up ☐ In the process of closing	
Name and contact information of the professionnal (if known) :	

SEND FORM AND RELEVANT DOCUMENTS FOR REQUEST TO :	
Email :	guichetaccesjeunesse.cisssmo16@ssss.gouv.qc.ca
Phone :	1-888-556-3991

[1] Parent's written authorization required
[2] Receipt and processing of a report

Name, first name : File :

REASON FOR REFERRAL: Describe reason for referral and specify known diagnoses

TREATMENT DISPENSED: Describe what has been done up to present to respond to needs

SERVICES RECEIVED CURRENTLY AND PREVIOUSLY (if known)

DATES	**PROFESSIONAL'S NAME AND PROFESSIONAL TITLE** (audiology, psychology, social services, psychoeducation, occupationnal therapy, speech therapy, nutrition, etc.)	**ORGANIZATION/ESTABLISHMENT**

PHYSICAL OR MENTAL HEALTH PROBLEMS KNOWN OR UNDER INVESTIGATION

MEDICATION: ☐ No medication

List of current and previous medications (if known)

NAME OF MEDICATION	**DOSE**	**CURRENT**	**PREVIOUS**	**DATE**
		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	

FAMILY HISTORY (Ex : speech delay, gross and fine motor delay, intellectual disability, ADHD, learning difficulty, any physical or mental health issue, drug or alcohol addictions, etc.)

*Please specify link with the client

EXPECTATIONS EXPRESSED BY CLIENT/PARENTS/GUARDIAN

Client currently presents difficulties : ☐ At home ☐ At school ☐ At daycare
☐ Other (specify) : _____

EXPECTATIONS EXPRESSED BY REFERRER

OTHER COMMENTS

PLEASE CHECK RELEVANT REASONS FOR CURRENT REQUEST

BEHAVIOUR/CONDUCT	
☐ Frequent anger/aggressiveness	☐ Substance abuse/addictions
☐ Opposition	☐ Frequent absence from school/daycare
☐ Impulsivity	☐ Tics (motor or verbal)
☐ Defiance/provocation	☐ Enuresis/encopresis
☐ Self-harming	☐ Hyperactivity
☐ Running away	☐ Suicide attempt
☐ Sexualized behaviour	☐ Difficulty with routine
☐ Trouble with the law	☐ Other (specify) :
INTERPERSONAL RELATIONSHIP	
☐ Conflictual sibling relationships	☐ Conflictual parent-child relationship
☐ Conflictual teacher-student relationship	☐ Victim of bullying
☐ Few or no friends	☐ Isolated/Withdrawn
☐ Conflict with peers	☐ Difficulties with social interactions
☐ Other (specify) :	
FAMILY CONTEXT	
☐ Context of neglect	☐ Intrafamily violence
☐ Placement history/DYP involvement	☐ Weak social network
☐ Context of vulnerability	☐ Substance abuse/addictions (family)
☐ Family conflicts	☐ Difficulty with transitions/changes
☐ Other (specify) :	
THOUGHTS	
☐ Weird ideas, hallucinations	☐ Homicidal thoughts
☐ Suicidal thoughts	☐ Traumatic memories/nightmares
☐ Self-image	☐ Other (specify) :
MOOD AND ANXIETY	
☐ Depression, sadness	☐ Worries
☐ Irritability, hypersensitivity	☐ Fears, phobias
☐ Feelings of despair	☐ Obsessive ideas, compulsions
☐ Emotional instability	☐ Panic attacks
☐ Avoidance	☐ Other (specify) :

Name, first name : File :

DEVELOPMENTAL DIFFICULTY :

☐ General development	☐ Learning
☐ Language, speech, pronunciation	☐ Attention and concentration
☐ Fluency of speech (stuttering, etc.)	☐ Understanding of questions, instructions
☐ Understanding of emotions	☐ Sensory issues
☐ Ability to communicate needs	☐ Sleep (sleep problems, etc.)
☐ Fine motor skills (holding ustensils, colouring, drawing, cutting out, doing up buttons, etc.)	
☐ Overall motor skills (crawling, walking, running, climbing/descending stairs, etc.)	
☐ Executive function	

LACK OF AUTONOMY : ☐ Dressing ☐ Feeding ☐ Hygiene
☐ Elimination, specifiy : ☐ Other (specify):

NUTRITION

☐ Premature birth	☐ Food allergies and intolerance
☐ Overweight, obesity	☐ Anemia/abnormal blood test
☐ Eating disorder's symptoms	☐ Other (specify) :
☐ Digestive system disorders (GERD, constipation, diarrhea, etc.)	
☐ Difficulties in introducing solids/progression in texture	
☐ Food restriction and refusal (selectivity, refusal, neophobia, picky eating, lack of appetite, etc.)	
☐ Faltering growth/weight loss/ difficulty following the curve	

REFERRER INFORMATION

Referrer's name and organization :		Phone :
		Fax :
Address :		Referrer's title :
City :	ZIP code :	Email :
If referrer is a doctor, license number :		
Signature of referrer :		Date : yyyy-mm-dd

AUTHORIZATION

The youth, aged 14 and over, or parent or legal representative authorizes the release of information to the referrer as the orientation of the request including the screening Agir tôt: ☐ Yes ☐ No

The youth, aged 14 and over, consents to the service request ☐ Yes ☐ No

The parent of the youth aged 14 and over has been informed of the service request ☐ Yes ☐ No

As client or legal representative, I authorize _____ to forward this service request to the Centre intégré de santé et de services sociaux de la Montérégie-Ouest and to share all information relevant to this request with the Guichet Accès Jeunesse

This authorization is valid for a period of **120** days from the date of signature of this document.

Signature of client or parent or legal representative : _____ Date : _____ yyyy-mm-dd

☐ **Verbal authorization obtain from youth** or parent or legal representative.

Name of the professional who obtained the verbal authorization : _____

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