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 ☐ Yes ☐ No
to the referrer as the orientation of the request including the screening Agir tôt:
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 : _____

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