

## APPLICATION FORM FOR YOUTH SERVICES

CLSC de Dorval-Lachine <input type="checkbox"/>	<b>Reserved section for the youth Guichet access</b> File number: _____ First name: _____ Last name: _____ Date of reference: _____ Date guidance: _____ Date of assignment: _____
CLSC de LaSalle <input type="checkbox"/>	
Name of the referent: _____	
Tel. no. : _____	
Fax no.: _____	

### Instruction for completion

The questions 1 to 5 can be completed by the parent(s) or the youth (14 years and over)

The questions 6 to 14 are completed by a professional

➤ Please attach all documents necessary for the review of the file

A response on the orientation of your application will be faxed within 3 weeks

### 1. CHILD

Name: \_\_\_\_\_ First name: \_\_\_\_\_

Date of birth    \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_  
                          Y        M        D

Permanent address : \_\_\_\_\_

Language spoken: French  English  Other  \_\_\_\_\_ Sex: F  M

School: \_\_\_\_\_ Additional services: \_\_\_\_\_

Name of doctor: \_\_\_\_\_

Health Insurance Number (*obligatory*) : \_\_\_\_\_ Exp date. : \_\_\_\_\_

Did the child receive other medical services at the CLSC? Yes  No

If yes, specify: \_\_\_\_\_

Name : \_\_\_\_\_

File Number : \_\_\_\_\_

<b>2. PARENT'S IDENTIFICATION</b>			
Mother :		Father :	
Address :		Address :	
☎ Home :	☎ Work :	☎ Home :	☎ Work :
☎ Emergency number :			
Occupation :		Occupation :	
Language spoken :		Language spoken :	
Date of birth :		Date of birth :	

<b>IMMIGRATION STATUS</b>			
	Father	Mother	Child
Country of origin			
Civil status			
Year of arrival			
Occupation			
Schooling			

<b>3. SIBLINGS</b>		
Name	First name	Age

Name : \_\_\_\_\_

File Number : \_\_\_\_\_

<b>4. FAMILY ENVIRONMENT</b>				
<input type="checkbox"/> Nuclear family (parents living with their children)				
<input type="checkbox"/> Single-parent family which child lives with :	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	Since :	
<input type="checkbox"/> Reconstituted family which child lives with :	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	Since :	
<input type="checkbox"/> Child lives in youth centre or with foster parents : Where? _____			Since :	
Date of separation / divorce :				
Who is the legal guardian :	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> shared custody	<input type="checkbox"/> Other
If shared custody, how much time is spent with each parents?				

<b>5. EVALUATIONS AND FORMER INTERVENTIONS (according to the parents)</b>						
PROFESSIONALS / ORGANIZATIONS	NAME AND ADDRESS	DATE		DIAGNOSIS  IF AVAILABLE	REPORT	
		BEGINNING	END		ATTACHED	TO COME
Family doctor						
Psychologist						
Child psychiatrist						
Social worker						
Speech therapist						
Neurologist						
Audiologist						
Special education teacher						
Occupational therapist						
Psycho educator						
Batshaw Youth Services						
Readaptation Centre (CRDI et CRDP)						
Others :						

Name : \_\_\_\_\_

File Number : \_\_\_\_\_

**SERVICES OFFERED WITHIN THE SCHOOL FRAMEWORK**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**COMMENTS**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Parent's signature: \_\_\_\_\_

Date: \_\_\_\_\_

Youth signature: \_\_\_\_\_  
(14 years and over)

Date: \_\_\_\_\_

*If you include reports or other documents which answer some of the questions on the form, it is not necessary to supplement the following sections.*

<b>6. HEALTH AND DEVELOPMENT HISTORY (prematurity, diseases, complications, delays in development, medication, hospitalizations, etc.)</b>
<b>7. SIGNIFICANT EVENTS (School, moving, migration, any kind of violence, any kind of abuse, loss, financial difficulties, disease of a relative, war, etc.)</b>

Name : \_\_\_\_\_

File Number : \_\_\_\_\_

<b>8. DESCRIBE CONCRETELY THE ACTUAL PROBLEM</b>

**FURTHER DESCRIPTION OF THE PROBLEMATIC SITUATION**

**Duration**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Frequency**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Intensity**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Area concerned (health, behaviour, family life, school life, social life, etc.)**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Is there a suicidal or homicidal risk? If yes, explain**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Name : \_\_\_\_\_

File Number : \_\_\_\_\_

**Interventions done**

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**COMMENTS**

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**IDENTIFY THE RISK AND PROTECTION FACTORS**

<b>Social network</b>	<b>Social contact</b>	<b>Relationship with the family (intra / extra)</b>
<input type="checkbox"/> Many friends / relatives <input type="checkbox"/> Some friends / relatives <input type="checkbox"/> Few friends / relatives <input type="checkbox"/> Absence	<input type="checkbox"/> Very frequently <input type="checkbox"/> Frequently <input type="checkbox"/> More or less frequent <input type="checkbox"/> Rare <input type="checkbox"/> Very rare	<input type="checkbox"/> Very good relationship <input type="checkbox"/> Good relationship <input type="checkbox"/> More or less good <input type="checkbox"/> Conflicting relationship <input type="checkbox"/> Inadequate relationship

<b>Relationship with others</b>	<b>Self image</b>	<b>Adaptability Capacities</b>
<input type="checkbox"/> Very good relationships <input type="checkbox"/> Good relationships <input type="checkbox"/> More or less good <input type="checkbox"/> Conflicting relationships <input type="checkbox"/> Inadequate relationships	<input type="checkbox"/> Very positive <input type="checkbox"/> Positive <input type="checkbox"/> More or less positive <input type="checkbox"/> Negative <input type="checkbox"/> Very negative	<input type="checkbox"/> Adapt very easily <input type="checkbox"/> Adapt easily <input type="checkbox"/> Adapt more or less easily <input type="checkbox"/> Difficult to adapt <input type="checkbox"/> Very difficult to adapt

<b>Parents difficulties</b>	<b>Child was victim of</b>
<input type="checkbox"/> Violence <input type="checkbox"/> Mental health <input type="checkbox"/> Drug addiction <input type="checkbox"/> Alcohol <input type="checkbox"/> Gambling <input type="checkbox"/> Others : _____	<input type="checkbox"/> Negligence <input type="checkbox"/> Incest <input type="checkbox"/> Sexual abuse <input type="checkbox"/> Act of violence / attack <input type="checkbox"/> Intimidation <input type="checkbox"/> Others : _____

Name : \_\_\_\_\_

File Number : \_\_\_\_\_

<b>What are the child's interests and strengths?</b>

**COMMENTS**


<b>9. WHO ARE THE CONCERNED PERSONS IN THE PROBLEM (family, social, or school network)?</b>

<b>10. WHAT DO THE PARENT / CHILD ATTRIBUTE THE PROBLEM TO?</b>

Name : \_\_\_\_\_

File Number : \_\_\_\_\_

<b>11. WHAT DID THE FAMILY ATTEMPT TO DO TO SOLVE THE PROBLEM?</b>

<b>12. WHAT IS THE MOTIVATION OF THE CHILD / FAMILY TO COMPLETE THIS APPLICATION FORM? WHAT ARE THEY READY TO DO AND WHAT ARE THEIR EXPECTATIONS?</b>

<b>13. SERVICES RECEIVED, CLINICAL RECOMMENDATIONS AND POSSIBLE COLLABORATION OF THE REFERENT</b>

Name : \_\_\_\_\_

File Number : \_\_\_\_\_

**14. CONSENT TO RECEIVE SERVICES**

I hereby authorize \_\_\_\_\_ (name of referent) of the establishment / institution \_\_\_\_\_ to send all pertinent information relative to study of my dossier by the Youth Guichet Access of the CSSS DLL.

I authorize the interveners of the Youth Guichet Access of the CSSS DLL to inform \_\_\_\_\_ (name of referent) of the orientation of the services.

I hereby consent to participate in the follow-up that will be offered by CSSS DLL or the Douglas Institute.

Signature of the father \_\_\_\_\_

And

Signature of the mother \_\_\_\_\_

Or

Youth (14 years and over) \_\_\_\_\_

***Consent of both parents or adolescent 14 years and over obligatory***

Referred by: \_\_\_\_\_

Occupation: \_\_\_\_\_

Phone number: \_\_\_\_\_

Fax number: \_\_\_\_\_

Signature : \_\_\_\_\_

Date : \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Year    Month    Day

**Please return the completed application form by fax to Youth Guichet Access:**

**Fax number :            514 639-0659**  
**Telephone:            514 639-0660 ext. 80537, H el ene Martin, secretary, for Youth Guichet Access**