JOSEPH BRANT HOSPITAL

Youth Early Intervention (YEI) Referral Form

The Youth Early Intervention (YEI) program is a clinical outpatient program at Joseph Brant Hospital. The program is funded by the Ministry of Health and Long Term Care. We work with youth who are experiencing emerging mental health or substance use issues and their families to identify their concerns and goals and to develop plans for recovery. The YEI program staff consists of an occupational therapist (OT), and a peer navigator.

The Mental Health Early Intervention Service has two streams:

1. The **transition support (TS)** stream provides transitional supports and system navigation to youth age 16-19 with mental health and/or substance use issues and their families who are moving from child/adolescent services into the adult system.
2. The **assessment and treatment (EI)** stream provides youth age 16-25 that require comprehensive assessment and treatment for untreated mental health and/or substance use issues. Young people in this stream will have access to a psychiatrist when appropriate.

The eligibility criteria for the **transition support (TS)** stream are as follows:

1. 16 to 19 years of age
2. are experiencing a mental health and/or substance use issue
3. received specialized child/adolescent mental health services within the last 12 months and will no longer be eligible for child/adolescent services within the next 12 months
4. live in Burlington, Ontario
5. referred by a professional at one of our community child and adolescent partners.

The eligibility criteria for the **assessment and treatment (EI)** stream are as follows:

1. 16 to 25 years of age
2. are experiencing a mental health and/or substance use issue
3. have mental health needs and want connection, assessment, and treatment for these concerns with no prior specialized child/youth mental health services within the last 6 months
4. live in Burlington, Ontario
5. referred by a family member or friend, referred by a physician, referred by other professional, or youth can refer themselves.

YEI staff will determine the young person's eligibility for the program upon receiving the referral. Send completed referral forms plus **relevant clinical information, including any assessments, consultations, psychiatric admissions, hospital or crisis team notes, neuropsychological testing, and rehabilitation reports** to intake at:

Joseph Brant Hospital
1182 North Shore Blvd.
Burlington, ON, L7S 1W7
Tel (905) 632-3737 Ext: 3506
Fax (905) 631-0513

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Fax completed form to Intake at Joseph Brant Hospital at (905) 631-0513
Date: _____

Your Information / Information about the Young Person

Name (at birth): _____
(first middle last)

Preferred Name: _____
(first middle last)

Date of Birth (DD/MM/YYYY): _____

Gender: _____

Preferred Pronouns: _____

Address: _____

City: _____ Postal Code: _____

Phone (preferred): ___(_____)_____

OK to leave a message? □ Yes □ No □ Unsure

Email: _____

OHIP#: _____ Version Code: _____

Expiry Date (YYYY/MM/DD): _____

If you are a young person referring yourself you are welcome to bring a person who is a support to you. Please fill out the family/friend section on page 3 with their information.

Referral Source Information

Referral Source: □ Self (complete portion above) □ Family Member □ GP □ Psychiatrist □ School □ ED Crisis Team □ Inpatient Unit □ COAST □ Other: _____

Name: _____

Organization:_____

Address: _____

City: _____ Postal Code: _____

Phone: ___(_____)_____

Email: _____

Fax: ___(_____)_____

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Will you or another person from your service have continued involvement with the young person you are referring? □ Yes □ No Who? _____

Reason for Referral (provide brief description):

Is this person aware of this referral and is agreeable to service? □ Yes □ No

Family / Friend / Support Person's Information

□ Same as referral source

Name: _____

Relationship: _____

Phone (preferred): __(___)_____

Secondary phone: ___(___)_____

Email: _____

Is this person aware you want them involved? □ Yes □ No

Family Physician Information

Do you/the young person have a family physician? □ Yes □ No □ Same as Referral Source

Physician Name: _____

Physician's Billing Number: _____

Physician Phone: _(_____)_____

Physician Fax: _(_____)_____

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About You / Profile of Young Person

Please list what your main areas of concern are / reason for referral:

Please list any services (including treatment and/or hospital stays) you have received for the concerns above and estimated dates:

Please list any medications you are currently taking or have taken in the past:

Currently suicidal? □ Yes □ No Previous suicide attempts □ Yes □ No	Details:
History of aggression? □ Yes □ No Legal issues related to aggression? □ Yes □ No Aggressive under the influence? □ Yes □ No	Details:

How did you hear about us? _____

Please attach copies of any available reports.