

Transitional Aged Youth Case Management Program

The **Transitional Aged Youth Case Management Program** provides case management support to transitional aged youth between the ages of 15-26 who are living with mental health and addiction issues in the west end of Toronto.

Eligibility Criteria

* 15-26 years old

* Individuals residing in the West Toronto Health Link (Yonge St west to Kipling, Eglinton south to the Lake.)

How to Refer

Referrals can be made directly to Reconnect by faxing completed referral forms to 416-248-6557.

For assistance, please contact Lucy O'Brien directly at lobrien@reconnect.on.ca

General Referral Form

Date of Referral

Client Information

Surname

Given Name

Middle Name

Alias

Date of Birth

Age

Health Card #

Version Code

Exp Date

Gender

Male

Female

Transgender

Transsexual

Decline to Answer

Other

Preferred Language

English

If Other, please
indicate preferred
language

French

Other

Address - Street

Apt #

City

Postal Code

Telephone #

Email:

Parent/Guardian Information #1

Full Name

Relationship	Legal Guardian	Yes
		No

Telephone #

Parent/Guardian Information #2

Full Name

Relationship	Legal Guardian	Yes
		No

Telephone #

Is the client aware of the referral and have you obtained explicit consent (written or verbal) from the client or their Substitute Decision Maker for this referral?

Yes No Unknown

Can we leave a confidential voice message with someone at this number?

Yes No Unknown

Are there any accessibility concerns?

Yes No Unknown

Details

Are there any safety concerns?

Yes No Unknown

If YES or UNKNOWN,
please include details/
comments

Referral Information

Has the client been connected to, or been involved with the following community supports?

Pediatrician Yes No

Psychiatry Yes No

Child and Youth Mental
Health Services Yes No

Hospital(s) (emergency
visits, inpatient or
outpatient services) Yes No

If yes, please specify

Mental Health Diagnosis/
Concerns

Addictions Concerns	Yes	Substances used
	No	

Physical Health
Concerns

Substitute Decision Maker	Yes	No	Unknown

Referral Source

Name

Agency/Relationship

Address

Fax #

Telephone #

Email

Please attach recent relevant reports, e.g. medical records, discharge summaries, etc.

Completed referral forms can be faxed to Reconnect Community Health Services
Fax: 416-248-6557 Tel: 416-248-2050 x 5231 www.reconnect.on.ca



Consent to the Collection and Disclosure of Personal Health Information

Reconnect wishes to provide you with health care services that meet your needs. This may involve the collection, disclosure or sharing of personal health information about you between Reconnect and other individuals or organizations.

I freely consent to Reconnect collecting my personal health information from, disclosing my personal health information to, or collecting my personal health information from and disclosing my personal health information to:

Person or Organization:

Name

Contact Address

Telephone

Limitations (if any) on the Collection or Disclosure of Personal Health Information:

I understand that I may withdraw this consent at any time by contacting my worker or the Privacy Officer at Reconnect. For questions regarding consent, please contact Reconnect's Privacy Officer at privacy.officer@reconnect.on.ca or at 416-248-2050.

Client Name:

Client Address

Date of Birth

Telephone

Client Signature _____

Today's Date:

Witness Name

Witness Signature _____

Substitute Decision Maker

Relationship to Client

Today's Date

SDM Signature _____

*If the SDM is a guardian, ask for the court order and make a copy for the file. If the SDM is an attorney for personal care, ask for the power of attorney for personal care and make a copy of the file.

** The list of SDMs in priority order is: guardian of the person, attorney for personal care, representative appointed by Consent & Capacity Board, spouse/partner, child/parent (includes CAS), parent with access right, sibling, any other relative, Public Guardian and Trustee.