RÉSEAU DE SANTÉ vitalité HEALTH NETWORK

Admission request form

Provincial Forensic and Tertiary Psychiatry Unit for Youth

Date: Region:

Primary contact person: Telephone:

Reason(s) for admission

Personal information

Legal name: Chosen name:

Sex at birth: Gender identification/pronouns: DOB:

Medicare no. DSD Health Services Card ID no.:

Language: Place of birth:

Current address:

Current residence: ◯ Own home ◯ Foster home ◯ Group home ◯ Relative's home

Other (specify):

Place of residence after discharge

Department of social development status

◯ Guardianship ◯ Custody agreement ◯ Custody order Expiry date:

Social worker: Tel.: Fax:

Youth's family

Is the child adopted?: ◯ Yes ◯ No

FATHER (Select ◯ BIOLOGICAL or ◯ ADOPTIVE)

Father's name: Telephone:

Full address:

Describe relationship with the youth:

Marital status: ◯ Single ◯ Married ◯ Separated ◯ Divorced ◯ Common-law

STEPPARENT (IF APPLICABLE)

Stepparent's name: Telephone:

Full address:

Describe relationship with the youth:

Marital status: ◯ Single ◯ Married ◯ Separated ◯ Divorced ◯ Common-law

MOTHER (Select ◯ BIOLOGICAL or ◯ ADOPTIVE)

Mother's name: Telephone:

Full address:

Describe relationship with the youth:

Marital status: ◯ Single ◯ Married ◯ Separated ◯ Divorced ◯ Common-law

STEPPARENT (IF APPLICABLE)

Stepparent's name: Telephone:

Full address:

Describe relationship with the youth:

Marital status: ◯ Single ◯ Married ◯ Separated ◯ Divorced ◯ Common-law

OTHER GUARDIAN (IF APPLICABLE)

Guardian's name: Telephone:

Full address:

Health condition:

Describe relationship with the youth:

SIBLINGS

Name: Age:

Name: Age:

Name: Age:

Name: Age:

Anticipated family involvement during stay

Individuals who are prohibited from contacting the youth

Name: Relationship:

Name: Relationship:

Suicide risk

Does the client have any suicidal thoughts? ◯ Yes ◯ No

Does the client have a history of previous suicidal gestures or attempts? ◯ Yes ◯ No

If yes, please describe:

Is there a history of suicidal gestures in the immediate family? ◯ Yes ◯ No

If yes, please describe:

Does the client have a detailed death by suicide plan (method, availability of method, date, place, lethality)? ◯ Yes ◯ No

If yes, please describe:

Risk factors

Does the client have a history of aggression towards others? ◯ Yes ◯ No

If yes, please describe:

Does the client have a history of aggression towards animals? ◯ Yes ◯ No

If yes, please describe:

Does the client have a history of destroying property? ◯ Yes ◯ No

If yes, please describe:

Brief overview of current challenges

Youth's strengths (explain)

Educational information

School and District:

Last grade completed:

Is the youth currently in school? ◯ Yes ◯ No | Significant absenteeism? ◯ Yes ◯ No

Is the youth receiving individualized services (educational assistant, individualized education plan, resources)? Specify:

Diagnosed learning disabilities? Specify:

School-based psychoeducational assessment done? Specify:

Youth's hobbies and interests

Describe the youth's hobbies, interests and community involvement (teams, organizations, affiliations):

Overview of family dynamics

Legal status (please check)

◯ Charges pending (and upcoming court date)

◯ Diversion

◯ Open custody

◯ Probation (expiry date and probation officer's name)

◯ Other (specify):

DESCRIBE PAST AND/OR CURRENT CHARGES, IF APPLICABLE:

Family history

Is there a family history of mental health issues such as

(depression, anxiety, ADHD, bipolar disorder, schizophrenia, obsessive compulsive disorder, etc.)?

In mother's family:

In father's family:

Suicidal behaviour?

In mother's family:

In father's family:

Any relatives with similar problems as this youth?

Drug or alcohol problems:

In mother's family:

In father's family:

If applicable, changes observed in the youth

◯ Behaviour	◯ Eating problems	◯ Energy level	◯ Muscle tension
◯ Mood	◯ Physical activity	◯ Sleeping habits	◯ Weight

◯ Other (specify):

Developmental profile

Age of father when child was born:	Age of mother when child was born:	
Was pregnancy planned?	Did mother receive prenatal care?	
Did mother have complications during pregnancy?		
Did mother use any drugs during pregnancy?	Type:	Quantity:
Did mother drink alcohol during pregnancy?	Quantity:	Frequency:
Did mother smoke during pregnancy?	Quantity:	
Is there a family history of epilepsy?		

Identify stressors experienced by parents during the youth's first three years

◯ Depression	◯ Financial hardship	◯ Illness
◯ Loss of employment	◯ Loss of loved one	◯ Housing problems
◯ Separation	◯ Family violence	◯ Other (Specify):

From birth to age 3

Who took care of the child?

Describe the child's mood:

Child's physical development:

At what age did the child: Walk: Talk: Become toilet trained:

Were there any problems with toilet training:

Were there motor development problems during this period (running, jumping, climbing, etc.)?

Where there any language problems during this period?

From age 3 to 5

Social development (ability to play with children of the same age, presence of friends, etc.):

Language development (sentence length, ability to be understood by others, vocabulary range, pronunciation, etc.):

Cognitive development during this period (in the average, slower or faster than other children of the same age:

Motor development (ability to maintain balance on their own, catch a ball, etc.):

Temperament (calmness, frequent outbursts, ability to be comforted, sociability, shyness, etc.):

During the first five years of life

Did the child develop any major illnesses?

Did the child sustain any head injuries?

Any other injuries?

Was the child hospitalized? If yes, how many times?

At what age and why?

Client health information

Family physician:	Tel.:	
Psychiatrist:	Tel.:	
Pediatrician:	Tel.:	
Psychologist:	Tel.:	
Other (specify):	Tel.:	
Date of last exam: Medical:	Dental:	Eye:
Health condition:	Height:	Weight:
Allergies and/or physical problems:		
Dietary restrictions:		
Current medications:		
Current diagnosis (specify):		

Please indicate all other assessments completed for this youth, (occupational therapy, psychology, etc.) and provide the name of a contact person for obtaining the results.

You must provide the Provincial Forensic and Tertiary Psychiatry Unit for Youth with all information, documents and reports relevant to the youth's case. If you do not have this information, these documents or these reports, please ensure that the organizations that hold them are listed on the consent form signed by guardian or the person legally authorized to give consent.