Ranch Ehrlo Society referral form

Before submitting this referral, please ensure you have the following documents ready to include:

REQUIRED:

- ☐ Health Services card & number
- ☐ Birth certificate
- ☐ Immunization record
- ☐ Status number (if applicable)
- ☐ Wardship documents (Section 9, Long Term Ward, etc)
- ☐ Funding approval (letter/email)

IF APPLICABLE (*if information requested is already included in any of the additional reports listed below, applicable sections can be left blank*):

- ☐ Cultural plan
- ☐ Education assessment
- ☐ Psychological assessment
- ☐ Recent photo
- ☐ Genogram
- ☐ Other _____
- ☐ Addictions assessments
- ☐ Court documents, probation order, undertaking
- ☐ Family plan
- ☐ Social history
- ☐ Out of home care child placement request
- ☐ Other _____

PARTICIPANT INFORMATION

Legal Last Name	**Legal First Name**	**Middle Name**	**Preferred name** (if applicable)
Sex at birth ☐Male ☐Female	**Gender** (if differs from sex at birth)	**Preferred pronouns**	**Date of birth** (DD-MON-YYYY)

PHYSICAL DESCRIPTION		
Height	Weight	Eye colour
Hair colour	Hair style	Complexion
Scars	Tattoos	Glasses?
Ethnicity	Other	

Birthplace	**Provincial health number**	**First Nation/band/Métis local and status number** (if applicable)	**NIHB number** (if applicable)

Child welfare status (ex. Sec 9, apprehension, LTW, etc)	**Legal status expiry date**	**Is English their first language?** ☐ Yes ☐ No	**Other language(s) spoken:**

Has a previous referral been made to our agency for this youth?
☐ Yes ☐ No

PARTICIPANT PLACEMENTS

Please add three most recent and anything additional in the text box below

Name/location of placement (present to past)	**Length of time**	**Comments** (reason for leaving/1:1 staffing?)

Is the participant currently enrolled in the Missing Youth Saskatchewan system ☐ Yes ☐ No

REFERRAL AGENCY INFORMATION

Legal name of referring agency	**Mailing address of referral agency**		
City	**Province**		**Postal code**
Primary contact name	**Phone**	**Email**	**Preferred method of contact** ☐ Phone ☐ Email ☐ Both
Supervisor's name	**Phone**	**Email**	**Preferred method of contact:** ☐ Phone ☐ Email ☐ Both
If you will be using Sask Interprovincial Courtesy supervision, have you applied? ☐ Yes ☐ No **Additional info**			

FUNDING INFORMATION

Funding approved: ☐ Yes ☐ No	**If no, please explain**:		
Will care and treatment invoices be sent to the referring agency? ☐ YES ☐ NO (If "No", please complete section below)			
Name of funding agency		**If Jordan's Principle**: ISC number Expiry date	
Mailing address of funding agency		**City**	**Province**
Postal code	**Email**		**Phone**
If invoices should be directed elsewhere, please indicate alternate address/email below:			
Mailing address of invoice office		**City**	**Province**
Postal code	**Email**		**Phone**
Does the participant have a diagnosed intellectual disability? ☐ Yes ☐ No ☐ Queried			

EDUCATION

Current school placement (last school if no current placement):		**Current grade**
Date last attended	**School address/location**	
Is the participant currently in a specialized program? ☐Yes ☐ No **If yes, please describe**		
Have any of the following assessments been completed (If yes, please include with submission)		
Psychoeducational assessment ☐ Yes ☐ No	**Occupational therapist** ☐Yes ☐No	**Speech/language** ☐Yes ☐No
Describe the participant's behaviour and attitude towards school.		

CULTURAL IDENTITY AND PERSONAL BACKGROUND

CULTURAL IDENTITY
Please describe the participant's cultural background or identify what is meaningful to them and their family. Are there any cultural activities, gatherings or ceremonies the participant is connected to, participates in, or would like to be connected to?
STRENGTHS AND INTERESTS
What are the participant's personal strengths or qualities they take pride in? Do they have any hobbies, community groups or interests (clubs, sports, arts, music, etc), goals/dreams/future plans they would like to pursue?
COMMUNITY AND SOCIAL CONNECTIONS
Does the participant have a connection to their home community? Please explain. Are there any cultural leaders, community members, or mentors who are actively connected and support the participant?
SPIRITUAL CONNECTIONS
Is the participant involved with any religious groups or engaged in any spiritual practices?

REASONS FOR REFERRAL/PRESENTING CONCERNS

Rating Scale (0 = No evidence/unknown, 1 = mild, 2 = moderate, 3 = severe)

EXTERNALIZING BEHAVIOUR		
	Rating	If rating other than 0, please describe using examples, frequency, intensity, type and any other information to help us to better understand. (severity, what gang, what substances, pull factors, etc)
Verbal aggression	0	
Physical aggression	0	
Property damage	0	
Running away	0	
Cruelty to animals	0	
Fire setting	0	
Sexually problematic behaviour (intrusiveness, aggression, high-risk)	0	
Sexually exploited/sex worker	0	
Gang involvement	0	
Substance use	0	
INTERNALIZING BEHAVIOUR		
	Rating	Please describe using examples, severity, frequency, intensity, type and any other information to help us to better understand.
Signs/indicators of anxiety	0	
Signs/indicators of depression	0	
Suicide ideation	0	
Suicide attempts	0	
Self-harm	0	

TRAUMA EXPOSURE TO PARTICIPANT

	Yes/No	Please describe using examples, frequency, intensity, duration, force, relationship to perpetrator, etc. to help us to better understand.
Emotional abuse		
Physical abuse		
Sexual abuse		
Emotional neglect		
Physical neglect		
Parental/caregiver divorce or separation		
Household physical violence		
Household substance violence/abuse		
Household mental illness or suicide attempt/completion		
Incarcerated household member(s)		
Medical trauma		
Natural disaster		
Grief/loss		
Community violence		

FAMILY/KINSHIP INFORMATION

Name of biological mother	First Nation/Metis local/band (if applicable)	
Relationship with participant/potential for reunification:	Address/Last known location	
Phone:	Phone contact allowed ☐ Yes ☐ No	Visits allowed ☐ Yes ☐ No
Name of biological father	First Nation/Metis local/band (if applicable)	
Relationship with participant/potential for reunification:	Address/Last known location	
Phone:	Phone contact allowed ☐ Yes ☐ No	Visits allowed ☐ Yes ☐ No
Name of primary caregiver (if different than above)	First Nation/Metis local/band (if applicable)	
Relationship with participant/potential for reunification:	Address/Last known location	
Phone:	Phone contact allowed ☐ Yes ☐ No	Visits allowed ☐ Yes ☐ No
Name of secondary caregiver (if different than above	First Nation/Metis local/band (if applicable)	
Relationship with participant/potential for reunification:	Address/Last known location	
Phone:	Phone contact allowed ☐ Yes ☐ No	Visits allowed ☐ Yes ☐ No

Siblings/relatives/other significant connections (community, family, friend, elder)

Name	Relationship to participant
Address/Location	Phone
Contact permitted: ☐ Yes ☐ No ☐Supervised ☐ Not presently, but would like to	
Name	Relationship to participant
Address/Location	Phone
Contact Permitted: ☐ Yes ☐ No ☐Supervised ☐ Not presently, but would like to	

Name	Relationship to participant
Address/Location	Phone
Contact permitted: ☐ Yes ☐ No ☐Supervised ☐ Not presently, but would like to	
Name	Relationship to participant
Address/Location	Phone
Contact permitted: ☐ Yes ☐ No ☐Supervised ☐ Not presently, but would like to	
Are any family members/significant connections currently in a Ranch Ehrlo program (ex. Family Treatment, Supported Living, Youth Group Living, Treatment Foster Care)	
Are there any people who this participant should not have contact with? If yes, who and why?	

LEGAL

Has the participant been involved in any illegal activities? ☐ Yes ☐ No **Do they have charges?** ☐ Yes ☐ No	**If yes to either question, please provide details:**	
Please provide contact information for any other relevant workers (ex. PO, RAMP, Legal Aid, etc)		
Name of worker	**Title/relationship**	**Contact info**
Name of worker	**Title/relationship**	**Contact info**

If there are any non-contact orders in place, please provide information below

Name	**Relationship**	**Details**

MEDICAL

HEALTHCARE PROVIDERS

Physician	**Name**	**Phone #/Location**
	Date last seen (approximate if seen within the last 12 months)	**Date of next appointment** (if applicable)
Dentist	**Name**	**Phone #/location**
	Date last seen (approximate if seen within the last 12 months)	**Date of next appointment** (if applicable)
Optometrist	**Name**	**Phone #/location**
	Date last seen (approximate if seen within the last 12 months)	**Date of next appointment** (if applicable)
Psychiatrist	**Name**	**Phone #/location**
	Date last seen (approximate if seen within the last 12 months)	**Date of next appointment** (if applicable)
Other (ex. SLP, OT, Counsellor)	**Name and designation**	**Phone #/location**
	Date last seen (approximate if seen within the last 12 months)	**Date of next appointment** (if applicable)

MEDICATIONS

Name of medication	Prescribing physician	Dosage (time/frequency)	Pharmacy	Are they actively taking the medication?

MEDICAL HISTORY

	Please provide details (severity, date of diagnosis, diagnosing Dr, how it is being treated/managed, has an assessment been completed)
Mental health disorders /diagnoses (ADHD, ODD, FASD,Bi-Polar, RAD, etc)	
Medical conditions (seizures, diabetes, asthma, cerebral palsy, etc)	
Is the participant experiencing paranoia/hallucinations auditory/visual?	
Allergies	
Dental/optical concerns	
Learning disabilities	
Eating/sleeping concerns	
Recent hospitalizations (ex. psychiatric, substance misuse, detox, etc). Include dates and details	
Communication & mobility needs (hearing, vision, expressive, receptive language, wheelchair, etc)	
Adaptive functioning (ability to care for oneself/hygiene/social skills)	
Immunizations Are they up to date/what was the last age they received them? Are there any personal beliefs towards immunizations we should be made aware of?	

CASE PLANNING

Please summarize the primary reasons for the referral. What present circumstances led to this referral being made?
What desired outcomes/expectations are there for the participant &/or family? **1.** **2.** **3.**
How is the participant engaged in their case planning? Are they aware that this referral has been made?
Are the participant's family/caregivers supportive of this referral? Please explain why/why not?
What is the anticipated period of treatment?
What is the participant's discharge plan and resource?

Please email the completed referral form to intake@ranchehrlo.ca

If you have any questions about this form or how to submit a referral, please contact our Intake Manager at 306-551-8004