



Transitional Aged Youth Outreach Program Professional Referral Form

The TAY Outreach Program is a strength-based, client centred service for youth (ages 16-24) who are experiencing substance use and/or mental health challenges and barriers staying connected to relevant support services. We offer community based counseling, case management services and consistent support to assist youth in making successful transition s into adulthood. Support is also available for parents/caregivers.

CLIENT INFORMATION:

DATE: _____ NAME: _____ D.O.B: dd/mn/yr _____

GENDER: _____

ADDRESS: _____ CITY: _____ POSTAL CODE: _____

HOME PHONE: _____ Permission to leave a message? Yes No

CELL PHONE: _____ Permission to leave a message? Yes No

Presenting Barriers (please click all that apply):

- | | | |
|--|---|---------------------------------------|
| <input type="checkbox"/> Substance use | <input type="checkbox"/> Housing | <input type="checkbox"/> Recreation |
| <input type="checkbox"/> Mental Health | <input type="checkbox"/> Legal | <input type="checkbox"/> Financial |
| <input type="checkbox"/> Emotional | <input type="checkbox"/> Criminal involvement | <input type="checkbox"/> Life skills |
| <input type="checkbox"/> Anger/Violence | <input type="checkbox"/> Physical Health | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Educational | <input type="checkbox"/> Parenting/Child | |
| <input type="checkbox"/> Employment/Career | <input type="checkbox"/> Trauma | |
| <input type="checkbox"/> Child Welfare involvement (CAS) | <input type="checkbox"/> Family/Partner | |

Known substances used in the past 3 months:

Is the client currently homeless or have a history of risk of homelessness? Yes No Unknown

Does the client experience barriers to core services at ADAPT office locations? Yes No Unknown
If yes, please explain: _____

Has the client been diagnosed with a mental health illness? Yes No Unknown

If yes, please identify the diagnosis(es): _____

Is the client taking prescription medication? Yes No Unknown

If so, please identify: _____

Has the client identified a need for support in the transition life areas (eg. education, employment, financial assistance, mental/emotional/physical health, housing, recreation, etc.)? Yes No Unknown

Is the client currently working with other service providers? Yes No Unknown

If yes, please identify: _____

Does the client have informal supports (family, friends, etc.)

Yes No Unknown

Please briefly describe your reason for referral and client risks (eg. present concern(s) and if not already highlighted above, please indicate in which areas the client could benefit from outreach support?)

Please list client's strengths:

REFERRAL SOURCE INFORMATION:

NAME: _____ AGENCY: _____

PHONE: _____ EMAIL: _____

Please indicate if a bridging meeting with the assigned TAY Counsellor is preferred? Yes No
Referring Counsellor's special instructions for assigned TAY Counsellor:

CONSENT: (to share personal client information for the purpose of a referral)

Signature of Client: _____

Date: _____

Signature of Referral Source: _____

Date: _____

REFERRAL TO TAY OUTREACH:

Please fax completed referral form to the ADAPT Milton Office - **905-876-1978**. Please include **ATTN: TAY** on the cover page and a TAY Counsellor will be in touch with you as soon as possible. Thank you!

If you require additional information or wish to speak further regarding the referral, please contact Jennifer Speers at 905-693-4249