

Referral Information

Client's Unique Identifier:

Date Received by DSO:

Click or tap to enter a date.

Current Service Team

Role	Name	Organization	Telephone	Email

Collateral Information Sources:

List of available reports and assessments for file review (i.e., psychological, psychiatric, hospital discharge summaries, genetic testing, Crisis Plan, OT/BT/SLP assessments, Person Directed Plans, Steps to Independence etc.)

Type of Report	Source / Organization	Date of Report	Completed by

Individual's Information
Client Profile
 (Summary of Individual's Current Situation)

Initial Reason for Referral:

Background History:

Background Info:

- Diagnoses
- Psychiatric disorder: are diagnoses being treated?
- Health Medical Condition: are all conditions being treated?
- Family history (siblings, where client grew up, who they lived with, any history of challenges, ex. Trauma, family mental health/health issues, loss of family members, etc.)

- Where client went to school, did they receive supports while in school, when did they graduate
- Any other life events, services accessed to address needs, are all issues being addressed.
- Client's perspective, what they want
- Family's perspective, what they need, challenges
- Issues with supports: are they being adjusted?

Previous community table outcomes:

Date: Presented to the UR community table in

- **Reason for referral:**
- **Outcome/Recommendations:**

Clinical Conference

- **Date:**
- **Reason for referral:**
- **Potential treatment bed goals:**
- **Outcome:**
- **Recommendations:**

Past Supports:

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Current Supports:

- **ODSP:** is enrolled in the Ontario Disability Support Plan.
- **Service Coordination:**
- **Passport Funding:** receives \$ in Passport funding per year.
- **Ontario Health at Home:**
- **SDM/POA/OPGT:**

Current Waitlist status:

- **MYSLP:**
- **Community Participation Supports:**
- **Supporting Housing:**
- **Person Directed Planning:**
- **Respite:**
- **Speech and Language Pathology:**
- **DSO assessment:** Completed in ; re-assessment completed in to reflect current support needs.

Biological Factors

Diagnoses:

- **Neurodevelopmental Disorders:**
 - Intellectual Disability / Intellectual Developmental Disorder
 - Global Developmental Delay
 - Unspecified Intellectual Disability / Unspecified IDD
 - Communication Disorders (e.g., Language Disorder, Speech Sound Disorder, Childhood-Onset Fluency Disorder (Stuttering), Social (Pragmatic) Communication Disorder)
 - Autism spectrum Disorder
 - Attention Deficit Disorder
 - Specific Learning Disorder
 - Motor Disorders (e.g., Developmental Coordination Disorder, Stereotypic Movement Disorder, Tic Disorders)
 - Other Neurodevelopmental Disorders (e.g., neurodevelopmental disorder associated with prenatal alcohol exposure)
- **Seizure Disorder:**
 - Frequency, type of seizures
 - Seizure protocol:
- **Genetic Testing:**

Medical Diagnoses and Treatments:

Physical Health:

Medical team and follow up is led by
Last completed physical examination was completed on

- **Diet / Appetite:** any recent changes or ongoing issues? Refusing food, weight loss, hoarding food, increase in appetite or weight gain?
 - Has there been a screen for bowel gastro-intestinal issues, e.g., reflux, H. pylori, discomfort or constipation? Any coughing with or after eating/feeding?
- **Dental:** Any dental issues? Last dental exam:
- **Vision:** Any vision impairments?
- **Hearing:** Any recent changes or ongoing issues?
- **Sleep:** Any recent changes or ongoing issues? Restlessness, decrease or increase in sleep times, daytime fatigue/napping, insomnia
- **Allergies:**
- **Bloodwork:** Are regular blood tests needed? Are they being completed?
- **Pain:** Could pain, injury or discomfort (e.g., fracture, tooth abscess, constipation) be contributing to the behaviour change(s)?
 - Have any pain assessments been completed?
 - Are modified pain charts needed or have been used?
- **Overall health:** Any recent deterioration in functioning, incontinence, memory, stamina, level of independence?
- **Other:**

	○ Ex. Diabetes ○ Ex. Arthritis ○ Ex. Past Surgeries ○ Ex. ABI Mobility Needs: is ambulatory/non-ambulatory and does/does not require a barrier free/accessible environment • Does the physical environment at the home meet the individual's mobility needs? • Are any mobility devices needed? • Recent deterioration or changes in movement or mobility (e.g., slow, agitated, coordination): Medication: • Adherence • Long term use impact • Side effects noted: • Past medications trialed and outcome • PRN ○ Usage/frequency: ○ PRN protocol: <u>Mental Health:</u> Diagnosis: • Psychiatry • What is baseline behaviour? • How have symptoms changed over time? • Any recent changes in ○ Anxiety or mood; irritability ○ Interest or initiative (e.g., leisure or work); withdrawal from activities ○ Social involvement <u>Crisis Plan:</u> <u>Ontario Health at Home:</u>		
Addictions/ Substance Abuse:	• What type of substances • When client started using, frequency • Types of supports accessed • Any diagnoses (substance use disorder)		
History of Hospitalizations:	Admission / Discharge date	Hospital	Reason for Admission

Medical Team:					
List of Current Medical Service Providers (those not listed in current service team) (i.e., Psychiatrist, Home and Community Care Coordinator, Physiotherapist, Neurologist, etc.)					
Type of Support	Name	Organization	Telephone	Fax	
Medication: List of Current Medications					
Medication	Dosage	Frequency	Purpose	Prescribing Doctor	Last Review Date:

Psychological Factors	
Communication:	Assistive Devices:
Adaptive Living Skills:	Personal Care/ADLs: • Dressing: • Hygiene:. • Meals: • Home management: • Finance: • Social interactions: Support Needs: At this time, would need : staffing supports to complete all daily living skills. From DSO's assessment report completed in • 's Support Needs Index Percentile Rank is at the percentile. • Exceptional Medical Support Needs:

	Exceptional Behaviour Support Needs:
Interests / Strengths:	From DSO's ASR report, list of gifts, likes, strengths. May be listed in school reports or other types of reports, PDP plan.
Behaviour Challenges:	The following information was compiled from <u>Behaviour Challenges:</u> - When did the challenging behaviour start? - Any past behaviours that were prevalent, but no longer observed? - Past BT supports that were effective, if not, why? Ex. Family could not follow mediator model due to high level of aggression, risk of injury - Any risks to others? - Other issues, for example, family cannot hire staff, potentially due to client refusing to allow others in home, challenges with hiring staff, environmental issues, high cost/high support need, hours are limited, etc. <u>Observed Challenging Behaviours:</u> - List of current observed behaviours, those listed in current BT plan <u>Potential Stressors:</u> - Those listed in BT plan, or as dislikes in DSO's ASR report that may trigger a negative response. - Those mentioned in other reports, interviews, etc. <u>Interventions/Strategies:</u> - Current strategies listed in BT report, or mentioned in other reports, during interviews, etc. Occupational Therapy: Summary of OT report, findings, recommendations, Date of report.
Social Factors	
Social (informal supports, external resources, Passport, respite status):	Are resources adequate to implement treatment, recreational, employment and leisure programs? Are there - Frequent caregiver changes or discontinuities of care - Direct care staff is adequately trained/educated for optimal support

	- Concerns regarding staff and family engagement in providing continuity of care: Are there signs of possible caregiver fatigue or burnout: - negative attitudes towards person with IDD - impersonal care - difficult to engage with staff - no or poor follow through of treatment recommendations - other: List current engagement with family, day programs, drop-ins, virtual programs, how Passport is being used, if respite is accessed and where, frequency.
Legal involvement:	N/A or list of past/current charges and outcomes, ORB status, etc.
Bio-Psycho-Social Chart:	See Appendix A at the end of the referral.

Assessment and Review with Service Team

Identified Issues

Issue/Concern/Risk	Resources Identified/Recommendations	Timeframe	By whom	Outcome
List of issues, risk factors				

Presentation to IRC

Date of Presentation to IRC:	2025-09-25
Presenters:	•

Presentation to IRC:	What are the identified barriers to supports, gaps in system that cannot be addressed with available resources? Reason for Referral: (include goals if referring for a treatment bed) Treatment Goals: (see template at the end of the profile)
Recent updates to the individual's situation:	

Discussion regarding identified barriers to support, gaps in system that cannot be addressed with available resources:	
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Issue Identified	Recommendation	Next Steps/Timeframe

IRC Outcomes – Review with the Service Team

Updates from service team:

Date	Issue Identified by IRC	Recommendation by IRC	Outcome	Review if unresolved or while waiting for a treatment bed
Click or tap to enter a date.				
Click or tap to enter a date.				
Click or tap to enter a date.				
Click or tap to enter a date.				
Click or tap to enter a date.				

Click or tap to enter a date.				
Referral completion:		Date: Click or tap to enter a date.		
		Reason for Referral:		
		Outcome/Resolution of identified concerns and issues:		
		Service Solutions Facilitator:		

Bio –Psycho-Social Framework

	Biological	Psychological	Social
Predisposing Factors	•	•	•
Protecting Factors	•	•	•
Precipitating Factors	•	•	•
Perpetuating Factors	•	•	•



Next Steps	•	•	•
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Bio-Psycho-Social Framework

	Biological (Physical) Factors such as genetics, hormone changes, alcohol and other drug use, brain injury	Psychological (Cognitive/Emotional) Factors such as trauma, loss, grief, coping skills, personality	Social (External factors) Factors such as discrimination, poverty, inadequate housing, lack of social support.
Predisposing Factors (increasing one's vulnerability to develop mental disorders (e.g., experiencing trauma predisposes someone toward developing PTSD))	• Issues related to aging (ex. Menopause) • Chronic physical illness • Caffeine, alcohol, non-prescription drug use • Genetics • Family risk history • Past diagnosis of mental illness • Prescription medication- long term use • Medical History • Seizure Disorder • ABI • Mobility issues • Chronic Pain • Past surgeries or procedures • Dietary restrictions • Memory issues (dementia related symptoms) • FASD	• Intellectual Disability; adaptive function • Neurodevelopmental Disorders • Communication Deficits • Emotional losses and grief in the past • Trauma/abuse/neglect in past • Personality traits • Anxious • Lack of insight • Social skill deficits (difficulties problem solving social situations, recognizing and avoiding risk, increasing risk for exploitation) • Limited choice (low self-determination) / powerlessness / dependency • Academic deficits • Low self-esteem • Vulnerability to stress • Difficulty managing emotions • Behavioural issues (aggression, self-injurious behaviours, stereotypes) • Language barrier	• Lack of resources, respite, financial, other • Lack of emotional support, family, friends; limited social network; fewer friendships; unsatisfying relationships, peer rejection • Rigid or inconsistent routines • Inadequate housing • Poverty (ODSP) • Discrimination; experience of marginalization and stigma / LGBTQ+ • Difficult living circumstances (higher risk for exposure to poverty and social disadvantage; accessing & maintaining appropriate community placements) • Higher exposure to negative life events (e.g., separation from primary caregiver, hospitalization, experiences of loss and trauma, exploitation, neglect, witnessing or experiencing physical, sexual, or psychological abuse) • Barriers to accessing health services (e.g., organizational barriers, lack of

			services, and poor quality services related to lack of knowledge in working with individuals with IDD) • Inadequate educational supports • Challenging family and social circumstances • Lack of opportunity or unsatisfying job or volunteer placements • Legal Charges/ ORB status
Protecting Factors (keeping it from being worse, person's strengths (e.g., community support))	• Younger Age • Physically Healthy • No mobility issues. • No alcohol/drug use • Appropriate medications • Good health care • SDM/OPGT/POA for treatment • Ontario Health at Home • Engages in exercise, healthy diet • Regular dental care • CTO- Community Treatment Order	• Positive relationship with others • No recent losses • Healthy coping skills • Higher language/communication skills • Personality traits (friendly, easygoing, engaging)	• Consistent and adequate social supports-housing, staff, family • Appropriate agency support • Access to caregivers when needed • Adequate day activities • Passport Funding • SDM for financial decisions
Precipitating Factors (triggering the onset of mental disorders, why are they being referred, what didn't work)	• Recent physical illness • Recent injury • Recent change in medications • Sleep loss • Recent deterioration or changes in movement or mobility	• Fear- identifiable source • Ongoing losses • Decreased cognition due to medication side effects • Non-stimulating environment • Frustration, stress	• Recent/pending social loss • Conflict with or among others • Recent lack of change in services or staff • Recent changes in family contact • Loss of day program/activities • Eviction, food insecurity

Perpetuating Factors (keeping a person sick, or preventing a person's recovery (e.g., poverty can perpetuate a mental illness by limiting access to treatment and support))	• Medication Issues • Pain/chronic effects of physical illness • Communication deficits (hearing, speech) • Psychiatric Illness • Addictions; limited modified programs • PRN is ineffective	• Ongoing sadness • Cognitive Level • Limited modified services for trauma • Inappropriate behaviour cannot be managed in current setting/environment	• Lack of Substitute Decision Maker (SDM) • Lack of social skills • Lack of access to or lack of services, use of Passport funding • Lack of individual program • Lack of knowledgeable/skilled staff or family
Next Steps	• Medication Review • Medical check-up • Genetic Testing for conditions or medication sensitivity • Track sleep; sleep study • Bowel movement tracking chart • Food intake chart; referral to a dietitian/nutritionist • Seizure protocol • Clarification of Diagnosis • Harm-Reduction/Recovery programs • Hearing/vision test • Non-verbal Pain chart • Referral to a specialized program (female clinician clinic for gynecology, seniors or geriatric programs, ABI clinics, FASD, etc.) • Refer to Health at Home's Family Managed care if appropriate • OT assessment for range of motion/assistive devices	• Review past reports (psychological, psychiatry, OT, BT, SPL, etc) • Identify clinical resources needed and potential options • Other community tables presentations • Speech and Language re-assessment • SKAAT- modified (Sexual Knowledge and Attitude Test) • Relationship groups • Social Skills groups • DBT/CBT • Lifeskills programs • Grief Counselling • Trauma informed care • ESL programs	• Identify community resources • Access funding if not using Passport funds; refer to a Passport broker agency if needed. • Review Person Directed Plan • Caregiver groups • Respite • Explore virtual if needed • Justice App • NCVI for families • Mindfulness