Children's Treatment Centre
Quinte Health
Belleville General Hospital
265 Dundas Street East
Belleville, ON K8N 5A9

Telephone: **(613) 969-7400 x2247**
Fax: **(613) 968-9154**
www.quintectc.com

Coordinated Service Planning (CSP) Referral Form

CONFIDENTIAL

Fax to 613-961-2529 Questions? Call 613-969-7400 x2508

A. CLIENT INFORMATION

Date of Referral: *(dd / mmm / yyyy)*		
Last Name:	First Name:	
Date of Birth: *(dd / mmm / yyyy)*	Gender: ☐ Female ☐ Male ☐ Other	Phone Number:
Address:	City:	Postal Code:
School/Childcare:		
Grade: (select grade)	Individualized Education Plan (IEP): ☐ Yes ☐ No	
Diagnosis:		

B. FAMILY/PARENT/GUARDIAN INFORMATION

Language(s) spoken at home: Is an interpreter required? ☐ Yes ☐ No

Do the family identify as Indigenous, First Nations, Inuit or Metis? ☐ Yes ☐ No

Is a member of the family part of the military? ☐ Yes ☐ No

PRIMARY CONTACT	Last Name:	First Name:
Relationship to Child: (select relationship)	*(if other or Agency, please specify)*	
(check all that apply) ☐ Legal Guardian ☐ Lives with Child		
Home Phone:	Mobile:	Email:
☐ Address is same as the child's ☐ Address is other than child's *(if Other, provide address below)*		
Address:	City:	Postal Code:

SECOND CONTACT	Last Name:	First Name:
Relationship to Child: (select relationship)	*(if other or Agency, please specify)*	
(check all that apply) ☐ Legal Guardian ☐ Lives with Child		
Home Phone:	Mobile:	Email:
☐ Address is same as the child's ☐ Address is other than child's *(if Other, provide address below)*		
Address:	City:	Postal Code:

C. DECISION-MAKING RESPONSIBILITY

Decision-Making Responsibility: ☐ No formal agreement ☐ Formal agreement in place ☐ Parents live together with child

If formal agreement in place, please describe (eg. sole, joint, etc.):

If parents are not together, all legal guardians are aware of and have consented to this referral: ☐ N/A ☐ Yes ☐ No
(if No, referral **CANNOT** be processed)

D. REFERRAL SOURCE INFORMATION

☐ **Family is self-referring** *(skip to next section E)* ☐ **Referral source is other than family** *(complete section D)*

Name of Referring Individual:	
Contact Phone Number:	Alternate Phone Number:
Are you a Service Provider? ☐ Yes ☐ No	
If yes, Agency/Organization and Role:	
If yes, who will lead the CSP?	
If yes, which CSP Tier is the family at? (select CSP Tier)	

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E. TEAM MEMBER INFORMATION

List below any agency/organization or individual that is also working with the child/youth (e.g. doctor, school, child care):

Agency/Organization Name	Contact Name	Phone Number

F. REASON FOR REFERRAL

Describe what you are hoping for from this service:

What are some of the strengths of the child/youth and family?

What is working well right now for this child/youth and family?

Is there anything else you want us to know?