sunbeam
DEVELOPMENTAL RESOURCE CENTRE

205 - 1120 Victoria St. N., Kitchener, ON N2B 3T2
Tel: 519-741-1121 Fax: 519-743-4730
Website: www.sdrc.ca

OAP – Urgent Response Services Referral Form

Referral Source Information			
Today's Date (dd/mm/yyyy):			
Name (Referring Individual):			
Agency/Organization:			
Phone Number:		Email:	
Reason URS is being requested – please check all that apply:	☐ Suicidal Ideation or Behaviour ☐ Self-Injurious Behaviour ☐ Violent Thinking ☐ Aggression ☐ Fire Starting	☐ Inappropriate Sexual Behaviour ☐ Harm to Animals ☐ Risk of Exploitation ☐ Flight Risk ☐ Property Destruction	
Please describe the behaviour of concern:			
Is the child/youth registered with the OAP?	☐Yes ☐No	OAP #: (if known)	
Have parents/guardians and/or youth consented to this referral?	☐Yes ☐ No **CONSENT MUST BE ATTACHED TO THE REFERRAL**		

Child/Youth Information			
Last Name:		First Name:	
Date of Birth:		Pronouns:	
Address:			
City:		Postal Code:	
Parent/Guardian # 1:		Relationship:	
Address:			
City:		Postal Code:	
Phone Number:		Email:	
Parent/Guardian #2:		Relationship:	
Address:		Postal Code	
Phone Number:		Email:	
Custody Arrangement:	☐Joint ☐Sole ☐ Formal Agreement ☐ No agreement ☐F&CS *Please include a copy of the custody agreement, if applicable.*		

Additional Information			
Language(s) Spoken:		Interpreter?	☐Yes ☐No
Who else is working with the child/youth? (Include school, behaviour services, specialists, etc.):			
Would you like to be contacted prior to us contacting the family?	☐Yes ☐No		

Referrals can be sent via email to j.russell@sunbeamcommunity.ca OR s.villaflores@sunbeamcommunity.ca OR by fax at 519-743-4730.

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Client ID #: _____

CONSENT TO SHARE INFORMATION

I/We _____ hereby consent to
Name of Parent/Guardian or Client (PLEASE PRINT)

Sunbeam Developmental Resource Centre (SDRC) obtaining/releasing information pertaining to:

_____ _____
Name of Client (PLEASE PRINT) **Date of Birth**

I/We consent to sharing information between SDRC and:

_____
Name of Agency/Person (PLEASE PRINT)

The purpose of sharing the information is to assist with planning on behalf of the client, and with accessing supports and services.

I know that I may withdraw my consent, in writing, at any time.

_____ _____
Signature of Parent/Guardian or Client- **Required** Date Parent/Guardian or Client Signed - **Required**

_____ _____
Witness Signature - **Required** Date Witness Signed - **Required**

Please describe any limitations to this consent (Lockbox):

_____
_____
_____
_____