CSBD
Community Services
OF BELLEVILLE
AND DISTRICT

REFERRAL

Behavioural Consulting Services

Behaviour Consulting Services (BCS) uses a Mediator Model to deliver service. The service goal is to assess and address the caregiver's behaviour and adjust their approach and response to positively impact the behaviour of concern. The client's behaviour is not the focus, rather, the behaviour of the caregiver/mediator.

Caregivers will be required to implement recommendations and report back to the Behaviour Consultant on a regular basis. To be successful and beneficial for all, it is important the caregiver be in a ready-to-learn state prior to the start of services.

Before facilitating or recommending a referral to BCS, please ensure readiness by considering the following:

- ☐ Is someone available to act as a mediator for service? (i.e. has the time and emotional readiness)
- ☐ Are the basic needs of the family/individual/caregiver being met? Consider, do they have;
  - Stable housing (including access to hydro, water, etc.)
  - Have adequate access to food
  - Acute medical and health needs have been addressed
- ☐ Where will services take place?
  - If the home is not a good fit for visits to occur, do they have access to transportation for travel to our office or community-based location for appointments?
- ☐ Is the family/caregiver aware BCS services are not counselling services designed to address mental health needs best addressed by a counsellor or therapist for the caregiver and/or client? (i.e. grief, trauma, attachment issues, addictions, relationship stressors).

* If the answer to any of the above is *no* or *unknown*, a BCS referral should be postponed until those needs have been addressed.

Referral Date: _____

Name: _____ **Pronoun:** _____

D.O.B.: _____ **Age:** _____

Family Information

Name of Primary Mediator: _____

Lives with: ☐ Mother ☐ Father ☐ Both ☐ Other, detail: _____

Parent(s)/Guardian(s): _____

Address: _____ (Street) _____ (City) _____ (Postal Code)

Phone: _____ (Home) _____ (Cell 1) _____ (Cell 2)

Email: _____

12 Moira Street East, Belleville, ON K8P 2R9
Tel: 613-966-7413 ● Fax: 613-966-2357 ● Toll Free: 1-800-966-7413
Email: csbd@csbd.on.ca ● website: www.csbd.on.ca

Others living in the home:

Referral Source Information

Name: _____ **Agency:** _____

Email: _____ **Phone:** _____

Referral Reason:

Referring Agency's involvement with this client and/or family:
(What role does this Agency/Individual intend to play during and/or following CSBD involvement?)

Goal for Behaviour Consulting Services involvement:

Diagnosis

Describe the individual's developmental disability and/or diagnosis:
(i.e.: IQ 70 or less, functioning at or below the 2nd percentile, etc.)

Recent Assessments:

Assessment	Assessor	Date

Other Agencies or Supports:

Name/Title	Agency	Phone
Family Physician:		
School:		
Workplace:		

Other Information:
(i.e.: medication, family information, funding such as ACSD, SSAH)

Documentation included with referral:

- ☐ Consent to Share Information
- ☐ _____
- ☐ _____
- ☐ _____

Signature

By signing below, I confirm I have read and reviewed this referral, and agree with its submission.

_____ _____
Person Referred Signature Date

_____ _____
Referring Person Signature Date