Centre intégré
de santé
et de services sociaux
de la Montérégie-Ouest
Québec

Facility: _____

File no.: _____

Last name, first name: _____, _____

Date of birth: _____ ☐F ☐M
YYYY MM DD

RAMQ NO.: _____ Exp. _____
YYYY-MM

Mother's name: _____

YOUTH INTERVENTION TEAM

- ❒ **REQUEST (YIT) (consultation-mediation)**
- ❒ **ISP REQUEST (YOUTH-YIT) (coordination)**

INFORMATION ABOUT THE APPLICANT:

Name:	Occupation:
Organization:	☎ Telephone:

PREVIOUS COLLABORATION METHODS (clinical collaboration, support-consultation, regular ISP, etc.)_____

_____

HAVE YOU DISCUSSED THE SITUATION WITH YOUR IMMEDIATE SUPERVISOR*, LIAISON AGENT, OR CUSTOMER SERVICE?

Yes ☐ No ☐

You must speak to him/her before submitting a request, failing which the YIT request may not be processed

YOUNG PERSON'S CONTACT INFORMATION:

Address:		City:
Postal code:	Tel. (home):	Mobile:
Email:		
Language: ☐ French ☐ English ☐ Other:		
Last name and first name of family physician:		
Does the young person take any medication ☐ Yes ☐ No If yes, specify: _____		

SCHOOL ATTENDANCE:

School:	Grade:
Daycare:	Adapted class:

FAMILY SITUATION:

Young person's living environment: ☐ Birth family ☐ Foster family ☐ Rehabilitation centre ☐ Other

If other than the birth family, name: _____

IDENTIFICATION OF PARENTS:

MOTHER		FATHER	
Last name, first name:		Last name, first name:	
DOB:		DOB:	
Address (if different from young person):		Address (if different from young person):	
City:	Postal code:	City:	Postal code:
Tel. (home):	Tel. (work):	Tel. (home):	Tel. (work):
Mobile:		Mobile:	
Custody: ☐ Physical ☐ Legal		Custody: ☐ Physical ☐ Legal	
Spouse:		Spouse:	

SIBLINGS:

NAME: _____ DOB: _____	NAME: _____ DOB: _____
NAME: _____ DOB: _____	NAME: _____ DOB: _____

FAMILY HISTORY (genogram, significant events, separation, bereavement, etc.):

EXPLANATION OF THE PROBLEM/ISSUES

DESCRIPTION OF PREVIOUS AND/OR ONGOING SERVICES

Type of service	Organizations involved	Names and contact information	Start of intervention	End of intervention

ACADEMIC INFORMATION (academic history, individualized education plan, attitudes and behaviours, academic abilities, relationships with peers, etc.):

MEDICAL AND PSYCHOSOCIAL INFORMATION (specific diagnoses, services required, physical or intellectual disability, substance abuse, etc.)

EXPECTED OUTCOMES

Applicant's signature | Institution | Date

TRANSMISSION OF YOUR REQUEST

1. Attach the consent form signed by the parents and/or the young person age 14 and over.
2. Attach any report and/or assessment that you feel would help in the evaluation of your request.
3. Please email your request to:

coordination.eij.cisssmo16@ssss.gouv.qc.ca