WHOLISTIC INTAKE FORM

Jordan's Principle MANITOBA

Jordan's Principle aims to reduce barriers experienced by First Nations children when trying to access support and care required to maintain a safe and healthy lifestyle. Jordan's Principle in Manitoba applies to First Nations children aged 0 to 17 and can help with a wide range of health, social and educational needs. For more information and specific eligibility criteria go to www.jordansprinciplemb.com.

How to use this form: The Wholistic Intake Form is meant to be used by workers in the Jordan's Principle system when enrolling a new client. It can be used in conjunction with culturally appropriate history-taking techniques.

Client Information			Date (mm/dd/yyyy):
First name:	DOB (mm/dd/yyyy):	Gender: M F X	
Last name:	Band:		
MHSC#:	PHIN:	Status #:	
Address:		Phone:	
Mode of Communication (circle): Speech / Sign Language / Gesture / Augmentative (symbol-based)			
Pref. Spoken Language:	Interpreter needed?: Y / N	Language:	
Client attends (circle): Head Start / Daycare / School (Grade:____) / Other:			

Parent/Legal Guardian/Caregiver Information		
Name:	Relationship to Client: Parent / Legal Guardian / Caregiver	
Address:	Phone:	
Is Client involved with a child & family agency? Y / N	CFS Worker's Name:	
Agency:	Phone:	

Other Family Members Involved	
	Phone:
	Phone:

Consent Forms
Enrollment Consent Form signed by: ☐ Child ☐ Parent/Legal Guardian ☐ Not signed
Information Exchange Consent Form signed by: ☐ Child ☐ Parent/Legal Guardian ☐ Not signed

Contact for Appointments
☐ Child (16 yrs & older only) ☐ Parent/Legal Guardian/Caregiver ☐ Other:

Wholistic Intake Form completed by:	
Name, Role, Organization:	Ph/Email/Fax:

Other Service Providers Involved		**OK to share updates?**
Jordan's Principle Case Manager:	Ph/Email/Fax:	Y / N
Primary Care Provider:	Ph/Email/Fax:	Y / N
Daycare/School Contact:	Ph/Email/Fax:	Y / N
Elder/Spiritual Care Provider:	Ph/Email/Fax:	Y / N
Mental Health Care Provider:	Ph/Email/Fax:	Y / N
Other:	Ph/Email/Fax:	Y / N
Other:	Ph/Email/Fax:	Y / N

Client Name:	DOB:	PHIN:

Reason for Intake

Mental, Emotional & Spirirtual Needs

If yes to any, describe above: ☐substance use ☐significant losses ☐abuse ☐trauma ☐mental health concern ☐self-harm

asQ Suicide Risk Screening Tool

1. In the past few weeks, has the Client wished they were dead? Y / N

2. In the past few weeks, has the Client felt that they or their family would be better off if they were dead? Y / N

3. In the past week, has the Cient been having thoughts about killing themself? Y / N

4. Has the Client ever tried to kill themself? Y / N

   If yes, how?

   When?

5. *(If yes to any of the above)* Is the Client having thoughts of killing themself right now? Y / N

   If yes, please describe:

■*If Client answers "No" to all questions 1 through 4, screening is complete (not necessary to ask question #5). No intervention is necessary.*

■*If Client answers "Yes" to any of questions 1 through 4, or refuses to answer, they are considered a positive screen. Ask question #5 to assess acuity.*

-"Yes" to question #5 = acute positive screen (imminent risk identified). Client requires an immediate safety/full mental health evaluation. Client cannot leave until evaluated for safety. Keep Client in sight. Remove all dangerous objects from room. Alert primary care provider.

-"No" to question #5 = non-acute positive screen (potential risk identified). Client requires a brief suicide safety assessment to determine if a full mental health evaluation is needed. Client cannot leave until evaluated for safety. Alert primary care provider.

Client Name:	DOB:	PHIN:

Physical Needs

Mobility: □Walking □Power Wheelchair □Manual Wheelchair □Other_____

Vision: □Functional □Impairment □Visual Aides Hearing: □Functional □Hearing Loss (Aided) □Hearing Loss (Unaided)

Diagnosed Conditions:

Medications:

Allergies:

Other relevant information:

Family & Social Situation

(living arrangements, current/past CFS involvement, current/past legal system involvement, bullying, peers, school involvement, interests)

Service Recommendations

□ Occupational Therapy assessment	
□ Manitoba Adolescent Treament Centre Rural & Northern Telehealth Ph: 204-958-6267 / 1-855-413-7855 Fax: 204-958-6260	
□ St. Amant Central Intake Ph: 204-258-7041 Fax: 204-258-7066	
□ Child & Adolescent Mental Health Service	
□ Manitoba First Nations Education Resource Centre	
□ Frontier School Division	
□ Rehabilitation Centre for Children Ph: 204-258-6720 / 1-855-884-8384 Fax: 204-258-6795	
□ Housing	□ Life Skills
□ Public Health	□ Education Support
□ Cultural Support	□ Employment Support
□ Spiritual Support	□ Sexual Health
□ Legal Support	□ Non-insured Health Benefits
□ Social Assistance	
□ Parenting Support	

Client Name:	DOB:	PHIN:

Additional Comments

Mental Health Crisis Resources

Local nursing station / health centre: _____
Klinic Crisis Line Ph: 204-786-8686 / 1-888-322-3019
MKO Mobile Crisis Team 1-844-927-LIFE (5433)
Kids Help Phone Ph: 1-800-668-6868 Text: 686868