COMMUNITY MENTAL HEALTH SERVICES

CHILD & ADOLESCENT REFERRAL

Call Toll Free: 1-888-310-4593

Access Office Use Only

CLIENT ID CONFIRMED: ☐YES ☐NO

Use CARE ☐YES ☐NO

REFERRAL DATE (DD/MMM/YYYY): ______________________________

NAME OF CHILD/ADOLESCENT: ____________________________ ____________________________ GENDER: __________
(FIRST NAME) (LAST NAME)

D.O.B: _________________________ AGE: _______ PHIN #: _____________________ MHSC #: _______________________
(DD/MMM/YYYY)

MAILING ADDRESS: __________ ______________________ ___________________________ _______ ____________
(PO Box #) (STREET #/NAME) (TOWN/CITY) (PROVINCE) (POSTAL CODE)

HOME PHONE #: _____________________ CELL #: __________________ **PERMISSION TO LEAVE VOICEMAIL?** ☐ YES ☐ NO

IS THE CHILD/ADOLESCENT AWARE AND AGREEABLE TO MENTAL HEALTH SERVICES? ☐ YES ☐ NO

PARENT AWARE OF REFERRAL: ☐ YES ☐ NO ☐ CONSENT OBTAINED FROM ALL LEGAL GUARDIANS_________________

INDIGENOUS STATUS: ☐ YES ☐ NO NEWCOMER TO CANADA: ☐ YES ☐ NO YEAR ARRIVED IN CANADA: ___________

NAME OF REFERRAL SOURCE: ____

☐ SELF ☐ PARENT/GUARDIAN ☐ PHYSICIAN ☐ SCHOOL _______________________ ☐ OTHER ______________________________

REFERRAL SOURCE TELEPHONE #:_________________________________ FAX #:_____________________________________

ADDRESS: ________ _____________________________ _________________________ ___________ ________________
(PO Box #) (STREET #/NAME) (TOWN/CITY) (PROVINCE) (POSTAL CODE)

INTERPRETATION SERVICES (available, if required): ☐ Language: ____

REASON FOR REFERRAL: **(CHECK ALL THAT APPLY):** SERVICE REQUESTED: ☐ PSYCHIATRY REFERRAL ☐ THERAPY/COUNSELLING

☐ DEPRESSION	☐ MOOD INSTABILITY / MANIA	☐ SLEEP / APPETITE DISTURBANCE
☐ ANXIETY	☐ OPPOSITIONAL BEHAVIOUR	☐ SUBSTANCE USE
☐ HYPERACTIVITY / IMPULSIVITY	☐ PSYCHOSIS	☐ MEDICATION
☐ INATTENTION	☐ RECENT LOSS / LIFE CHANGE	☐ THREATS / HARM TO OTHERS
☐ SUICIDAL IDEATION ☐ Recent ☐ Past	☐ SELF-HARM ☐ Recent ☐ Past	☐ OTHER_________________________

(PLEASE SPECIFY-As space is limited, we encourage attaching an additional page/letter to the referral form):

DURATION OF PROBLEM: ☐ *Under 3 months* ☐ *6-12 months* ☐ *1year+*

PAST/PRESENT MENTAL HEALTH DIAGNOSIS: ☐ YES ☐ NO (IF YES, PLEASE SPECIFY...) _________________________________

PAST/PRESENT MEDICATIONS: ☐ YES ☐ NO (IF YES, PLEASE SPECIFY...) ____

If this is a mental health emergency please call the mental health crisis line at 1-888-617-7715 or proceed to your local hospital emergency department.

LEGAL GUARDIAN INFORMATION (please list all parents/guardians):

NAME/CONTACT: ____________________ **Relationship:** ☐ Parent ☐ CFS Agency ☐ Foster Parent ☐ Other_______________

ADDRESS (IF DIFFERENT FROM CHILD): ________ (PO Box #) ______________________ (STREET #/ NAME) _____________________ (TOWN/CITY) ___________ (PROVINCE) ____________ (POSTAL CODE)

HOME PHONE #: ______________________ CELL #: __________________________ WORK #:____________________________

NAME/CONTACT: ____________________ **Relationship:** ☐ Parent ☐ CFS Agency ☐ Foster Parent ☐ Other_______________

ADDRESS (IF DIFFERENT FROM CHILD): ________ (PO Box #) ______________________ (STREET #/ NAME#) ____________________ (TOWN/CITY) ___________ (PROVINCE) ____________ (POSTAL CODE)

HOME PHONE #: ______________________ CELL #: _______________________ WORK #:_______________________________

CHILD RESIDES WITH: ________________________ **CUSTODY ARRANGEMENT, IF SO LIST**: _______________________________

☐ PERMISSION TO LEAVE VOICEMAIL, IF ONLY FOR A SELECT NUMBER PLEASE NOTE: ___________________________________

NAME OF CURRENT SCHOOL ATTENDING: ____ Grade: ____________________

Has this child received any formal assessments/tests (Psychology, CDC, Connors, etc.): ☐ YES ☐ NO

If YES, please attach report to referral and specify: ____

NAME OF FAMILY PHYSICIAN: ____

NAME OF PSYCHIATRIST/PSYCHOLOGIST/OTHER MENTAL HEALTH PROFESSIONAL: _____________________________________

PAST/PRESENT MEDICAL CONDITIONS: ☐ YES ☐ NO (IF YES, PLEASE SPECIFY): ____

PAST/PRESENT INVOLVEMENT WITH MENTAL HEALTH PROGRAM/COUNSELLING: ☐ YES ☐ NO

(IF YES, PLEASE SPECIFY): ____

SIGNATURE OF PERSON COMPLETING THE REFERRAL: ____

DECLARATION OF CONSENT:

I am aware that the personal and health information about my child (or me) contained in the form is being forwarded to the Child and Adolescent Community Mental Health Program. I hereby consent to forwarding any relevant documentation for my child along with making this referral to Southern Health-Santé Sud.

____ Signature of Parent/Client

__________________________________ Date

******* Missing Information will delay the referral process *******

PLEASE INCLUDE ALL RELEVANT DOCUMENTATION (REPORTS, LETTERS, ETC.)

PLEASE SEND COMPLETED FORM BY FAX TO MENTAL HEALTH ACCESS SERVICES AT 204-239-0451

CE DOCUMENT EST AUSSI DISPONIBLE EN FRANCAIS

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