Reset Form

COMMUNITY MENTAL HEALTH SERVICES

CHILD & ADOLESCENT REFERRAL

Call Toll Free: 1-888-310-4593

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)

ADDRESS: _____ _____ _____ _____
(STREET #/NAME/ BOX #) (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

ABORIGINAL STATUS: ☐ YES ☐ NO PARENT AWARE OF REFERRAL: ☐ YES ☐ NO

NAME OF REFERRAL SOURCE: _____

☐ SELF ☐ PARENT/GUARDIAN ☐ PHYSICIAN ☐ SCHOOL _____ ☐ OTHER _____

REFERRAL SOURCE TELEPHONE #:_____ FAX #:_____

ADDRESS: _____ _____ _____ _____
(STREET #/NAME/BOX #)) (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): _____

_____

_____

_____

_____

_____

_____

_____

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 1-866-588-1697 or proceed to your local hospital emergency department.

NAME OF PARENT/GUARDIAN: _____ **PERMISSION TO LEAVE VOICEMAIL**? ☐ YES ☐ NO

ADDRESS: _____ _____ _____ _____
(STREET #/ NAME/BOX #)) (TOWN/CITY) (PROVINCE) (POSTAL CODE)

HOME PHONE #: _____ CELL #: _____ WORK #:_____

NAME OF PARENT/GUARDIAN: _____ **PERMISSION TO LEAVE VOICEMAIL?** ☐ YES ☐ NO

ADDRESS: _____ _____ _____ _____
(STREET #/ NAME/BOX #)) (TOWN/CITY) (PROVINCE) (POSTAL CODE)

HOME PHONE #: _____ CELL #: _____ WORK #:_____

NAME OF CURRENT SCHOOL ATTENDING: _____ Grade: _____

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

If YES, please attach to referral. (IF YES, PLEASE 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): _____

OTHER AGENCIES INVOLVED: (e.g. Public Trustee, Power of Attorney, Employment & Income Assistance, Child & Family Services, Workers Compensation Board, Manitoba Public Insurance, Probation, Housing supports, Court/Legal matters, Adult Community Disability Services)

☐ YES ☐ NO If yes, please specify: _____

Agency Contact(s):_____

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

Bonjour Hello CE DOCUMENT EST AUSSI DISPONIBLE EN FRANCAIS

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