



LAST NAME	(FIRST)
MRN	VISIT NUMBER
DATE OF BIRTH YYYY-MM-DD	SEX
ADDRESS	
IMPRINT OR ENTER DETAILS BY HAND	

## Referral Form

Agency Client #: \_\_\_\_\_ MRN: \_\_\_\_\_ Date of Request: \_\_\_\_\_  
YYYY - MM - DD

Coordinating Agency:  AFS  Dilico  EMYS  HANDS  SOAHAC  Weechi-it-te-win  Woodview

Referring Agency: \_\_\_\_\_

Location: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Fax # Report is to go to (1# per agency / location): \_\_\_\_\_

Case Manager: \_\_\_\_\_

Severity scale prior to service as per case manager:  1  2  3  4

- First Consultation  Follow Up  
 Professional-to-Professional Consultation  Re-Assessment (If the date of original consultation is 1 year or more prior to this request)

Dates Not Available: \_\_\_\_\_  
\_\_\_\_\_

Family Doctor or Paediatrician: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Telephone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

### Information that is mandatory for referral to proceed

- Consent form  Case Summary / Assessment

### Information provided for consultation (if available)

- Admission History  Police Synopsis  Discharge Summary  
 Fire setting Assessment (if applicable)  BCFPI (if applicable)  
 CAFAS (if applicable)  Risk / Needs Assessment (if applicable)

- Reports:  Education Assessment  Drug & Alcohol Assessment  Psychological Assessment  
 Speech & Language Assessment  Fire setting Assessment  School  Relevant Medical Information  
 Social History  Previous Psychiatric Consultations or other Consultations  Service Plan or Case Notes  
 Youth Justice Court Documents (please specify)  Other Behavioural Checklists: Please list



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### CLIENT INFORMATION

Patient's Name: \_\_\_\_\_  Male  Female DOB: \_\_\_\_\_  
YYYY - MM - DD

Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Health Card #: \_\_\_\_\_ Version: \_\_\_\_\_ Exp.: \_\_\_\_\_  
YYYY - MM - DD

Guardian Name(s): \_\_\_\_\_

Guardian Contact #: Primary: \_\_\_\_\_ Secondary: \_\_\_\_\_

Is legal guardians' address the same as clients?  Yes  No If No please complete address section

Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

- Custodial Status:**  Intact  Joint\*  Sole Custody\*  Temporary Care Agreement  
 Temporary Care and Custody Order  Supervision Order  Society Wardship Order  
 Crown Wardship Order  Child protection order for custody (s. 65.2)  
 Customary Care Agreement  Kinship Agreement

\* Please provide legal documentation

### Residence Information

- Resides with:  Bio-Mother  Bio-Father  Step-Mother  Step-Father  Same Sex Parents  
 Adoptive Mother  Adoptive Father  Extended Family  Independent Living  
 Other (please explain): \_\_\_\_\_

Please list complete names of individuals the client resides with and how they are related (i.e. sister, brother, step-father):

\_\_\_\_\_

**Resides where:** (if other than family home)

- Foster Home  Group Home ( Short-Term  Long-Term)  Detention Centre  Secure Setting  Open

**Custody Setting:**  Custody / Detention Centre Treatment Program:  Yes  No Other: \_\_\_\_\_

**School Grade:** \_\_\_\_\_  Regular Class  Special Education  Day Treatment  Section 23  Not Attending

Language(s) spoken by client:  English  French Other: \_\_\_\_\_

Is an interpreter required?  Yes  No

Language(s) spoken by parent(s):  English  French Other: \_\_\_\_\_

- Aboriginal  First Nations  Metis  Inuit  On Reserve  Off Reserve

Currently before the courts  Yes  No  Sentenced / YJ

Explanation: \_\_\_\_\_

Tele-Mental Health Services,  
provided by



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Reason for Referral:  Full Consultation re:  Diagnosis  Medication  Management:

Questions to be answered from this consultation (please be specific and attach additional information if needed):

Parent(s) / Guardian(s) Concerns (attach additional information if needed):

Medical Problems and Allergies:

Family History of Mental Illness (please specify and attach additional information if needed):



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### MAJOR CONCERNS (Check those that apply)

- Developmental Delay     FAE / FAS     Socialization Problems
- School Problems:     Academic     Behavioural     Truancy     Other: \_\_\_\_\_
- ADHD:     Inattentive     Impulsive     Hyperactive
- Oppositional Defiant
- Aggressive Behavior:     Verbal     Physical     Other: \_\_\_\_\_
- Antisocial Behavior:     Substance Abuse     Alcohol     Drug     Firesetting     Other: \_\_\_\_\_
- Conflict with the law    Please specify: \_\_\_\_\_
- Sexual Acting Out:     Current     Past    Please Specify: \_\_\_\_\_
- Mood Problems:     Depression     Mood Swings     Elevated Mood
- Suicidal Behaviors:     Current     Past    Please Specify: \_\_\_\_\_
- Self-Harm:    Type: Please Specify: \_\_\_\_\_
- Anxiety     Obsessions     Compulsions     Worry     Avoidant Behavior
- Somatization     Sleep Problems
- Eating Disorder:    Please explain \_\_\_\_\_
- Family Conflict:     Separation from Parents / Family     Grief     Other: \_\_\_\_\_
- Strange, Bizarre Behavior:     Hallucinations     Delusions
- Witnessed Traumatic Events:     Physical     Emotional     Sexual
- Experienced Trauma:     Physical     Emotional     Sexual

- 
- Interventions:**     None Currently     No previous Agency involvement
- Counselling:     Individual     Family     Parent     Group     Other: \_\_\_\_\_
1. Involved in Specialized Program: \_\_\_\_\_
2. Had Previous Mental Health Assessments e.g. psychiatric, psychological, TAPP-(C), etc., (Not Telepsychiatry)
- No     Yes    Date: \_\_\_\_\_    By Whom: \_\_\_\_\_
- YYYY - MM - DD



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3. Is this child/youth currently involved with any other Mental Health Agency or Psychiatrist?

\_\_\_\_\_

### 4. Current Medications

Stimulant

Name and Dosage: \_\_\_\_\_

Name and Dosage: \_\_\_\_\_

Name and Dosage: \_\_\_\_\_

SSRI or other Anti-Depressant

Name and Dosage: \_\_\_\_\_

Name and Dosage: \_\_\_\_\_

Name and Dosage: \_\_\_\_\_

Mood Stabilizer

Name and Dosage: \_\_\_\_\_

Name and Dosage: \_\_\_\_\_

Name and Dosage: \_\_\_\_\_

Anti-Psychotic

Name and Dosage: \_\_\_\_\_

Name and Dosage: \_\_\_\_\_

Name and Dosage: \_\_\_\_\_

Anti-Anxiety

Name and Dosage: \_\_\_\_\_

Name and Dosage: \_\_\_\_\_

Name and Dosage: \_\_\_\_\_

Other meds

Name and Dosage: \_\_\_\_\_

Name and Dosage: \_\_\_\_\_

Name and Dosage: \_\_\_\_\_