| Date:       *(yy/mm/dd)* |  Name of Individual: Last, First | CID:       |
| --- | --- | --- |
| **Date of Birth**     *(yy/mm/dd)* | **Heath Card #**      **VC**       | **Home Phone No.**       | **Cell Phone No.**       |
| **HomeAddress**      | **City**      | **Postal Code**      |
| **Parent/Guardian Information:**  |
| **Box 1**  |
| **Full Name(s)**      | **Relationship to Child/Youth**      |
| **Verbal Consent obtained from parent/guardian:** Yes **[ ]**  No **[ ]** If no, please explain:      |
| **Address Same as Child/Youth [ ]** If not, fill out address below |
| **Street Address**      | **City**      | **Postal Code**      |
| **Home Phone No.**      | **Cell Phone No.**      | **Other Phone No.**      | **A confidential message** **can be left at home**Yes **[ ]**  No **[ ]**  |
|  |
| **Box 2** *Use this box to provide information of second parent/guardian when residence differs and there is joint/shared custody.* |
| **Full Name(s)**      | **Relationship to Child/Youth**      |
| **Verbal Consent obtained from parent/guardian:** Yes **[ ]**  No **[ ]** If no, please explain:      |
| **Address Same as Child/Youth [ ]** If not, fill out address below |
| **Street Address**      | **City**      | **Postal Code**      |
| **Home Phone No.**      | **Cell Phone No.**      | **Other Phone No.**      | **A confidential message** **can be left at home**Yes **[ ]**  No **[ ]**  |
| **Reason for Referral:**What is your question(s)for the Psychiatrist? Please be specific so we can answer your question(s) as efficiently and accurately as possible.      **Medical History:**Medication: Yes **[ ]**  No **[ ]**  Specify current and past medications:      Past medical health history: Yes **[ ]**  No **[ ]**  Specify:       Past mental health treatment/diagnosis/admissions: Yes **[ ]**  No **[ ]**  Specify:      Current mental health support: Yes **[ ]**  No **[ ]**  Specify:      What interventions have been attempted to address the concern(s) you are asking about. Please specify:      Is child/youth currently seeing a Psychiatrist? No **[ ]**  Yes **[ ]** Specify Psychiatrist:      Please provide the date the child/youth was last seen by Physician:       Psychiatrist:       ***Please attach the last visit note.*****Physician Information:****Referring Physician**      **Billing #**      **Direct Phone # (Backline)**      **Fax #**      **Physician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Fax your referral to Here24/7 at 1-844-437-3329** **for processing during regular business hours.****Please note that if you need an urgent or crisis response for a child / youth,** **please contact Here24/7 by phone at 1-844-437-3247.*****Thank you for attaching any supporting documentation you feel would be helpful.*** |
|  |
| CC: Client Family:       Date:       Referral Source/GP:       Date:       Other:       Date:        |