| 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: | | | | | | | |