| **Date of Birth:** (yy/mm/dd) | Name of Individual: Last, First | **CID:**       |
| --- | --- | --- |
|  |
| **Demographics of Person Seeking Service *(Attach label here if available)*** |
| **Client** |
| Preferred Name: |       | Date: | Click here to enter date  |
| Gender: |       | Preferred language: |       |
| Home Address: |       | City: |       | Postal Code |       |
| Home Phone: |       | Cell Phone: |       | [ ]  | Ok to leave a message |
| Email: |       | Best time to reach client: |       |
| **Parent/Guardian Information** |
| Full Name: |       | Relationship to child/youth |       |
| Verbal Consent obtained from parent/guardian: | [ ]  | Yes | [ ]  | No |
| If no, please explain: |       |
| Address same as child/youth: | [ ]  | Yes | [ ]  | No | If no, fill out address below |
| Home Address: |       | City: |       | Postal Code |       |
| Home Phone: |       | Cell Phone: |       | [ ]  | Ok to leave a message |
| Email: |       | Best time to reach client: |       |
| *Use this box to provide information of second parent/guardian when residence differs and there is joint/shared custody.* |
| Full Name: |       | Relationship to child/youth |       |
| Verbal Consent obtained from parent/guardian | [ ]  | Yes | [ ]  | No |
| If No, please explain |       |
| Address same as child/youth | [ ]  | Yes | [ ]  | No | If no, fill out address below |
| Home Address: |       | City: |       | Postal Code: |       |
| Home Phone: |       | Cell Phone: |       | [ ]  | Ok to leave a message |
| Email: |       | Best time to reach client: |       |
| **Referral** |
| Family Physician: |       | Health Card #: |       | Version Code |       |
| Living Situation: | Choose an item. | Other (specify): |       |
| **Reason for Referral**  |
| List your questions for the psychiatrist. *Please be specific so we can answer your question(s) as efficiently and accurately as possible* |
|       |
| **Medical History** |
| Past Medial Health History – *Please specify below:* |
|       |
| Medications: | **[ ]**  | Yes | **[ ]**  | No |
|  |
| **Medications** | **Current** | **Past** | **Dose/Frequency** | **Response and Adverse Effects** |
|       | [ ]  | [ ]  |       |       |
|       | [ ]  | [ ]  |       |       |
|       | [ ]  | [ ]  |       |       |
|       | [ ]  | [ ]  |       |       |
|       | [ ]  | [ ]  |       |       |
| **Mental Health Treatment/Diagnosis/Admissions** |
| Past Mental Health Treatment/Diagnosis/Admissions *I.e., date of onset, diagnosis, treatments, admissions* |
|       |
| Specify current mental heath support *(i.e., agencies, hospitals, treatment providers, community supports)* | [ ]  | Yes | [ ]  | No |
|       |
| What interventions have been attempted to address the concern(s) you are asking about. Please specify: |
|       |
| Is child/youth currently seeing a Psychiatrist? | [ ]  | Yes | [ ]  | No |
| If yes, specify psychiatrist: |       |
| Please provide the date the child/youth was last seen by: |
| Physician: |       | Psychologist: |       |
| **Physician Information**  |
| Referring Physician: |       | Billing #:  |       |
| Direct Phone #: |       | Fax:  |       |
| Physician Signature:  |       | Date: |       |
|  |  |
| **\*\*Please attach the last visit note including any and all MH consultations outside of CMHA, BW results, EKG results, and Height/Weights- growth chart, and any supporting documentation you feel would be helpful** |
|  |
| **Fax your referral to Here24/7 at 1-844-437-3329 for processing during regular business hours** |
| CC: Client Family:       Date:       Referral Source/GP:       Date:       Other:       Date:        |