| **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: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |