

Child and Adolescent Outpatient Referral Form Mental Health and Addictions

SECTION A: Client Information Client/family consent to referral? Yes No

Client Name: _____ HC with Version Code: _____
 Client Preferred Name: _____ Date of Birth: _____ (dd/mm/yyyy)
 Address: _____ City/Town: _____
 Client's Telephone: (H) _____ Leave Message: Yes No
 (C) _____ Leave Message: Yes No
 Consent to speak with Parent/Caregiver (12 yrs+) Y N Leave message with Parent: Yes No
 Parent/Caregiver Name: _____ Relationship to Client: _____
 Birth Gender: Male Female Identified Gender: _____
 Name of Family Physician: _____ Phone Number: _____

SECTION B:

Psychiatric Diagnosis / Main Presenting Concern(s): _____

SECTION C: Risks

Concern	Present (within past 6 months)		Past (6 months or more)		Denied	Unknown
	Yes	No	Yes	No		
Alcohol / Substance Use						
Violent Behaviour						
Suicidal Ideation						
Suicidal Attempts						
Self-Harming Behaviour						

If answered yes above, please identify / report concerns: _____

SECTION D: Current Agency Involvement

- | | |
|--|---|
| <input type="checkbox"/> Pathstone Mental Health | <input type="checkbox"/> Addiction Services (Specify) _____ |
| <input type="checkbox"/> Family and Children's Services (FACS) | <input type="checkbox"/> HC&CS / Mental Health and Addictions Nurse |
| <input type="checkbox"/> Developmental Services (eg. Bethesda) | <input type="checkbox"/> Private / EAP |
| <input type="checkbox"/> School Social Worker | <input type="checkbox"/> Niagara Region |
| <input type="checkbox"/> Niagara Health System | <input type="checkbox"/> Other _____ |

Contact Niagara Involvement – Past / Present? Yes No – Send Contact Niagara Registration Form

SECTION E: NH Service Requested (Internal): **McMaster Service Requested – MAU, 3G (external):**

Fax Referral to: 905-704-4406

- Crisis Social Worker
 Admission to Unit and send to Crisis Social Worker
 Psychiatric Consultation

Fax Referral to: 905-688-9951

- Brief Services Social Worker
Criteria for Children / Youth:
- Ages 8 years and up; and
 - High risk to self / others; and
 - Mental health treatment / therapy focus ONLY
 - Reside in Niagara Region / remain in Niagara for next 1-2 months; and
 - Consent to treatment, including referral to ongoing mental health services; and / or
 - No connection to community services

Completed By (Print Name) _____

Referral Date (dd/mm/yyyy) _____

Referring Physician _____

MD/NP Billing Number / Signature _____



REF43

Chart Copy – Do Not Destroy