niagarahealth
Extraordinary Caring. Every Person. Every Time.

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

- ☐ Pathstone Mental Health
- ☐ Family and Children's Services (FACS)
- ☐ Developmental Services (eg. Bethesda)
- ☐ School Social Worker
- ☐ Niagara Health System
- ☐ Addiction Services (Specify)____________________
- ☐ HC&CS / Mental Health and Addictions Nurse
- ☐ Private / EAP
- ☐ Niagara Region
- ☐ Other ____________________

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

SECTION E: NH Service Requested (Internal):

☐ Crisis Social Worker

☐ Admission to Unit and send to Crisis Social Worker

☐ Psychiatric Consultation

McMaster Service Requested – MAU, 3G (external):

☐ 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

Rev. 11/2021(v3)

REF43

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