Intake Referral Form for Collaborative Psychiatric Outreach

This form must be completed by a mental health clinician only

- The primary mandate of Child, Youth & Family Mental Health Collaborative Psychiatric Outreach services is to provide assessment and/or short term treatment by a Child and Adolescent Psychiatrist for children and youth up to age 18. Indirect consultation to family physicians and/or community mental health and substance use teams can also be provided for non-referred patients.
- The ongoing involvement of community physicians and mental health professionals is essential to support the continuing needs of these clients. Our goal is to communicate with families and involved professionals throughout our process of assessment and treatment and we encourage you to contact us.

REFERRAL PROCESS

1. **Complete 2 sided form (please print) and fax to (250) 519-6789. The Consent must be signed by the child and the legal guardian.**
2. Relevant reports and assessment documents must be faxed to CYFMHS Intake (250) 519-6789.
3. **Completion of this form does not guarantee admission to the service.**

Mental Health Intake Referral Form

Referral Date: _____ PHN: _____

Child Surname _____ First Name: _____

Age: _____ DOB: _____

Referral Source/Agency: _____ Phone: _____

SSICS Contact Person: _____ Phone: _____

Consent

I_____ (Legal Guardian) and _____ (Child/Youth 12 years and older) Give consent for Child, Youth & Family Mental Health Service employees to receive and share information related to the mental health assessment and treatment needs of: _____ with other involved professionals in order to facilitate the provision of continuing care.

Signature of Legal Guardian: _____ Date: _____

Signature of Child: _____ Date: _____

Witness: _____ Date: _____

CLIENT DOES NOT WISH FAMILY TO BE INVOLVED/INFORMED ☐

Guardianship

Legal Guardian: _____
Last name *First name*

Address: _____
Street Address

Relationship: _____

Home Phone: _____ Cellular Phone: _____

_____

Child Resides With: _____ Relationship: _____

Child's Residence Address: _____

Physician and School

Family Physician: _____
Name *Phone number*

Current Medications _____

School: _____

School Contact: _____ Phone: _____

Referral Information

Reason for Referral: _____

_____

_____

_____

Summary of Clinical presentation and mental health concerns: _____

_____

_____

_____

Current Diagnosis: _____