CHILD AND YOUTH SPECIALIZED PSYCHIATRIC AND MENTAL HEALTH SERVICES INTAKE REFERAL FORM

Name of Referring Physician: ________________________ **Date of Referral:** ______________________

Office Address:	Office Phone:
	Office Fax:
	Billing Number:

PATIENT INFORMATION

Name:	Health Card Number:
Date of Birth:	Gender at Birth: ☐ Male ☐ Female
Address:	Preferred Pronoun:
	Patient Cell Number:
	Home Number:
Patient's Preferred Language: ☐ English ☐ French ☐ Other please indicate:	

PARENT/GUARDIAN INFORMATION *MANDATORY*

Parent/Guardian #1:	Relationship to patient:
Address: (if different from above)	Tel. #:
Parent/Guardian #2:	Relationship to patient:
Address: (if different from above)	Tel. #:

If parents are separated / divorced, who has custody:

☐ Parent #1 ☐ Parent #2 ☐ Joint ☐ Other: ___________________________

CAS Involvement? ☐ Yes ☐ No If yes please provide contact info: __________________________

REASON FOR REFERRAL

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Referral Question:

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CURRENT MEDICATIONS & DOSAGES

Name of Medication	Dose

HAS THE PATIENT EXPRESSED RISK RELATED TO?

Symptoms of psychosis ☐Y ☐N Harm to self or others ☐Y ☐N Eating Disorder ☐Y ☐N

Details: (incl. Heart Rate):____

Please advise the patient and family that in Ontario children and youth are entitled to confidentiality. CHEO's policy is to obtain consent from youth 12 and over, unless deemed incapable. In order for CHEO Mental Health to contact families regarding this referral, youth aged 12 and over must first complete this section providing permission to share information with parents/caregivers. Otherwise we will contact the youth (rather than the parent) regarding this referral.

MUST BE COMPLETED BY PATIENT

WHO WOULD YOU LIKE US TO CONTACT FOR THIS REFERRAL: ☐ Me (patient) ☐ Mother ☐ Father ☐ Other:________________

BEST TIME TO CONTACT BY PHONE: ☐ 8 am - 12pm ☐ 12 pm - 4 pm ☐ 4 pm - 6 pm

Best number to reach: _________________________

I ___________________________________, (patient's name) give my consent to CHEO Mental Health Intake service to speak with my:

☐ Mother ☐ Father ☐ Other: ________________ Signature of patient: ____________________________

Physician's signature: ____

Please fax completed referral to 613-738-4235

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