Community Addiction and Mental Health Services
Services communautaires de santé mentale et de dépendances

***Referral Form***

# Child & Youth Mental Health Services

**Cornwall Community Hospital/Hôpital communautaire de Cornwall**
850 McConnell Avenue, Cornwall ON, K6H 4M3 – Phone: 613-361-6363 – Fax: 613-361-6364

| Date of Referral: | Referral Source: |
|---|---|

| **Office Use Only:** | |
|---|---|
| Anzer CPI File #: | InterRai #: |
| Date of Intake Assessment: | Information Source: |
| ☐ First Referral ☐ Re-referral | |

| **Client Information** | | |
|---|---|---|
| Name: | D.O.B.: | Age: |
| OHIP # & Version Code:<br>Expiry Date: | Sex: ☐ Male ☐ Female | Gender: ☐ Male ☐ Female |
| Address: | City: | Postal Code: |
| Youth Phone Number: | Contact Youth Directly: ___Y | |
| School/Day Care: | Grade/Placement: | |

| **Family Information** | | |
|---|---|---|
| ***Who has the legal right to make decisions for this youth?*** | | |
| ☐ Mother ☐ Father ☐ Both ☐ Youth ☐ CAS ☐ Other (specify): | | |
| ***Youth resides with:*** | | |
| ☐ Mother ☐ Father ☐ Both ☐ CAS ☐ Other (specify): | | |
| Mother's Name: | | |
| Mother's Address: | | ☐ Same as referred child/youth |
| Telephone Numbers | Residence: | Work: |
| | Alternate: | |
| Father's Name: | | |
| Father's Address: | | ☐ Same as referred child/youth |
| Telephone Numbers | Residence: | Work: |
| | Alternate: | |
| Legal Guardian/Foster Parent/Caregiver Name: | | |
| Relationship: | | Address: |
| Telephone Numbers | Residence: | Alternate: |

## *Referral Form*

### ►*Siblings*

| Name: | Age/DOB: |
|---|---|
| Name: | Age/DOB: |
| Name: | Age/DOB: |
| Name: | Age/DOB: |

### ►*Medical Information*

| Family Physician: | Physician Tel. Number: |
|---|---|
| Medical/Psychiatric Diagnosis: ☐ Yes ☐ No<br>Describe: | Medication(s): ☐ Yes ☐ No<br>Describe: |

### ►*Current/previous contact with other hospital/community program(s)?*

| Agency/Service | Period of Involvement | Worker | Closing Date |
|---|---|---|---|
| ☐ CHEO | ☐ Current ☐ Previous ☐ Waiting List | | |
| ☐ Children's Aid Society | ☐ Current ☐ Previous ☐ Waiting List | | |
| ☐ Children's Treatment Centre | ☐ Current ☐ Previous ☐ Waiting List | | |
| ☐ Eastern Ontario Health Unit | ☐ Current ☐ Previous ☐ Waiting List | | |
| ☐ Counselling & Support Services of SD&G | ☐ Current ☐ Previous ☐ Waiting List | | |
| ☐ L'Équipe Psycho-sociale | ☐ Current ☐ Previous ☐ Waiting List | | |
| ☐ Mental Health Crisis Team | ☐ Current ☐ Previous ☐ Waiting List | | |
| ☐ S.D. & G. Developmental Services | ☐ Current ☐ Previous ☐ Waiting List | | |
| ☐ CCAC – MHAN | ☐ Current ☐ Previous ☐ Waiting List | | |
| ☐ Other: | ☐ Current ☐ Previous ☐ Waiting List | | |

### ►*Reason for Referral / Primary concern*

______________________________________________________________________

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►Are the parent(s)/guardian(s) aware of this referral? ☐ Yes ☐ No

►Is the youth aware of the referral? ☐ Yes ☐ No

***Please attach signed consent to the referral form***