niagarahealth

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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

Client's E−mail: _____

Consent to speak with Parent/Caregiver (12 yrs+) Y ☐ N ☐ Leave message with Parent: ☐ Yes ☐ No

Parent/Caregiver Name: _____ Relationship to Client: _____

Parent/Caregiver E−mail: _____

Birth Gender: ☐ Male ☐ Female Identified Gender: _____

Name of Family Physician: _____ Phone Number: _____

SECTION B:

Psychiatric Diagnosis / Main Presenting Concern(s):

SECTION C: Risks **Please complete the following chart**

	Present (within past 3 months)		Past (3 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 ☐ Niagara Health System

☐ Family and Children's Services (FACS)

☐ Developmental Services (eg. Bethesda)

☐ School Social Worker ☐ Private / EAP

☐ Addiction Services (Specify) _____

☐ HC&CS / Mental Health and Addictions Nurse

☐ Niagara Region

☐ Other _____

SECTION E: NH Fax Referral to: 905−688−0683

☐ Counselling / Therapy
Included: ☐ HEADS ED ☐ CSSRS ☐ Psychiatry Notes ☐ SW Note

☐ Psychiatric Consultation

☐ Other: _____

☐ High Risk Social Worker (Completed by Crisis SW only)
Included: ☐ HEADS ED ☐ CSSRS ☐ Psychiatry Notes ☐ SW Note

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

Fax Referral to: 905−688−9951

☐ Brief Services Social Worker

Criteria for Children / Youth:

- Ages 10 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

Consent and Agreement

I, the undersigned, agree to the exchange of personal health information between the referring agency listed above and Pathstone Mental Health for the purpose of referral, treatment planning, coordination and follow up services/supports. I further agree to the exchange of personal health information between Pathstone Mental Health and the referring agency listed above for the purpose of referral, treatment planning, coordination and follow up services/supports. In addition, I agree to an Intake Clinician at Pathstone Mental Health contacting me for purposes of completing an intake if required.

Signature: _____ Date: _____

OR ☐ Verbal consent for above, obtained from / relationship / date: _____

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Chart Copy − Do Not Destroy

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