



**For Internal Use Only:**

FILE NO. \_\_\_\_\_  
 CSMS \_\_\_\_\_  
 STAR \_\_\_\_\_  
 TRIAGE \_\_\_\_\_  
 CAIP \_\_\_\_\_

**REFERRAL FORM  
 CHILD AND ADOLESCENT OUTPATIENT SERVICES  
 PSYCHIATRIC AND MENTAL HEALTH PROGRAM**

**FOR EMERGENCY SITUATIONS PLEASE SEE 'ACCESSING CHILD AND ADOLESCENT SERVICES AT GRH'**

<b>NB: PLEASE COMPLETE ALL SECTIONS ● FAX (519)749-4301</b> <b>● ATTACH COPIES OF RELEVANT REPORTS ●</b>	
<b>Has this referral been discussed with the family?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO <b>Does the child/teen support this referral?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO	
Patient's name:	Date of referral: (year/month/day)
Patient's date of birth: (year/month/day)	Health card # and version code:
<b>Note: patient must be less than 19 years</b>	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Home address: City:	Postal code:
<b>Note: see reverse for catchment area</b>	
Parents/Guardian Name(s):	
Phone: (home) (daytime):	
<b>Does patient/family consent for Child and Adolescent Services to leave message?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO	
Referring physician/agency contact:	Initial:
Address: City:	Postal Code:
Phone #: Fax #:	<b>Referring physician #:</b>
<b>Reason for referral:</b>	
<b>SERVICES REQUESTED:</b> <input type="checkbox"/> <b>Psychiatric Consultation/Treatment ONLY</b> or <input type="checkbox"/> <b>Multidisciplinary Team</b> <i>(This requires physician referral)</i>	
<b>Note: Multidisciplinary team may include nursing, occupational therapy, psychiatry, psychology, resource teacher, social work depending on age/assessed need.</b>	
Is this patient currently awaiting trial? <input type="checkbox"/> YES <input type="checkbox"/> NO If <b>yes</b> , please note referrals are accepted only for assessment of serious psychiatric/mental health concerns in which clinical deterioration is imminent.	
Are there active or pending court proceedings regarding custody/access of this patient? <input type="checkbox"/> YES <input type="checkbox"/> NO If <b>yes</b> , please note referrals are accepted only for assessment of serious psychiatric/mental health concerns in which clinical deterioration is imminent. <b>Note: In cases where parents share joint custody, Child and Adolescent Services must obtain permission from BOTH parents prior to scheduling an appointment for the patient to be seen.</b>	
Current Medications:	
Other MD's/Agencies/Counselors currently involved:	
Other MD's/Agencies/Counselors involved in the past:	
<b>Thank you for your referral. Upon receipt of the fax, Child and Adolescent Services will contact the family/patient and arrange an appointment. You will receive notification. If we identify that alternative or additional service(s) are required, we will provide the family/patient with that information.</b>	