CHILD & YOUTH MENTAL HEALTH PROGRAM
REFERRAL FORM

McMaster Children's Hospital

McMaster Children's Hospital, Child and Youth Mental Health Program is responsible for delivering highly specialized mental health services to children and youth from birth to their 18th birthday. Some of the services we provide are accessed via single-access-point organizations across the region. To be eligible for all of our services and to facilitate discharge planning, please contact the CONTACT organization in your area simultaneous to making this referral. If your request is to access primary or secondary level child and youth mental health services, please contact your local CONTACT organization first.

CONTACT: Hamilton 905-570-8888 Brant 519-758-8228 Niagara 905-684-3407 Haldimand - Norfolk 1-800-265-8087

When submitting this referral, please include available supporting documents and reports (e.g. previous mental health and psychiatric assessments, psychological testing reports, relevant medical reports etc.)

Please fax this completed form and attachments to 905-521-7938 to initiate your referral.

REFERRAL SOURCE ❑ CONTACT Agency ❑ ER ❑ Hospital ❑ Physician ❑ Nurse Practitioner ❑ Regional Service Outreach Partner

Name of Person completing form:_____ Signature:_____ Date:_____ (year/month/day)

Have you made a referral to your local CONTACT agency? ❑ Yes ❑ No

CLIENT INFORMATION

Last Name_____ First Name_____ Middle Name_____

Date of Birth_____ Age_____ HIN #_____ Expiry Date_____

Address_____ Phone #_____

FAMILY INFORMATION (Please Check if Applicable) ❑ Crown Ward ❑ Temporary Ward ❑ Society Ward

Legal Guardian:

(Step Mother/Foster/Adoptive) Mother: Last Name_____ First Name_____

Phone #_____ Alt #_____

(Step Father /Foster /Adoptive) Father: Last Name_____ First Name_____

Phone #_____ Alt #_____

Marital Status: ❑ Married ❑ Divorced ❑ Single ❑ Other - _____

Is the family system supportive? ❑ Yes ❑ No ❑ Unknown

REFERRING PHYSICIAN (Mandatory for Accessing Services)

Last Name_____ First _____ Phone #_____

Address _____ Fax #_____

Physician Signature_____ **Date**_____ OHIP Billing #_____

Family Physician (If different from Referring)_____

SCHOOL/DAYCARE INFORMATION

School/Daycare:_____ Contact Person:_____ Phone #_____

Is this child attending school/daycare regularly? ❑ Yes ❑ No ❑ Unknown

Is this child's current school/daycare placement at risk? ❑ Yes ❑ No ❑ Unknown

Is this a Rapid Response request (available to daycares in Hamilton only)? ❑ Yes ❑ No ❑ Unknown

Is there a Significant Medical History? ❑ No ❑ Yes -_____

Allergies:_____

FAX REFERRAL - Date: (yyyy/mm/dd) _____ **(712522 - 2009-07) Page 2 OF 2 for:**

Last Name_____ First Name_____ Middle Name_____

Date of Birth_____ Age_____ HIN #_____ Expiry Date_____

Is there a Significant Medical History? ❑ No ❑ Yes - _____

Allergies:_____

CURRENT MEDICATIONS: Include prescription and non prescription medications including:

- oral meds / liquids
- inhalers
- injectables
- "tube" feeds
- patches
- eye / ear drops
- nasal mists
- vitamins / supplements / diet pills
- herbal / natural products
- creams / ointments

Medication (general name preferred)	**Dose** (include units)	**Route**	**Frequency** (note if prn)	**Start Date** (yyyy/mm/dd)	**Prescribed By**

REASON FOR REFERRAL / PRESENTING PROBLEMS: _____

Comments:

Substance/Alcohol Misuse: ❑ Yes ❑ No ❑ Unknown _____

Thoughts of Self Harm: ❑ Yes ❑ No ❑ Unknown _____

Engaged in Self Harm: ❑ Yes ❑ No ❑ Unknown _____

Thoughts of Suicide: ❑ Yes ❑ No ❑ Unknown _____

Suicide Attempt(s): ❑ Yes ❑ No ❑ Unknown _____

Thoughts of Harm to Others: ❑ Yes ❑ No ❑ Unknown _____

Engaged in Harm to Others: ❑ Yes ❑ No ❑ Unknown _____

High Risk Behaviour(s): ❑ Yes ❑ No ❑ Unknown _____

Legal Involvement: ❑ Yes ❑ No ❑ Unknown _____

Parental Mental Health Issues: ❑ Yes ❑ No ❑ Unknown _____

Siblings Mental Health Issues: ❑ Yes ❑ No ❑ Unknown _____

SERVICES CURRENTLY INVOLVED WITH CHILD/FAMILY:

❑ CONTACT - Hamilton ❑ CONTACT - Brant ❑ CONTACT - Niagara

❑ CONTACT - Haldimand / Norfolk ❑ Child Protection ❑ Speech and Language Pathology

❑ School/Learning Resources ❑ Developmental Services ❑ Family Health Team

❑ Therapeutic/Counseling ❑ Mental Health Services ❑ Other_____

PREVIOUS MENTAL HEALTH SERVICES (If any):_____

For Office Use Only **Disposition :** ❑ **Accepted** Assigned To:_____

❑ **Declined** If declined, was the referral redirected to the local CONTACT? ❑ Yes ❑ No

Appointment Date (yyyy/mm/dd) _____ Time (hh:mm) _____

Printed Name_____ Signature/Designation_____ Date_____
(yyyy/mm/dd)