Child & Adolescent Mental Health Clinic Referral Form

Person Sending Referral

Name:	Date of Request
Position	Phone Number

******** EACH QUESTION ON THE FORM MUST BE COMPLETED********

Have you explained the multidisciplinary team members to the parents? Y or N

Have you suggested to the parents to have the child seen by their family doctor/NP? Y or N

Does the family need: Community resource navigation and/or Assessment from clinical team

Have the caregiver(s)/parent(s) completed a parenting program? Y or N _____

Is the child displaying symptoms of ADHD, anxiety or depression? Y or N

If so, which one?_____

Client Information

Name:	**DOB (yy/mm/dd):**
Age:	**Gender/Pronouns:**
School:	**Grade:**
Assessments Completed: **(OT, Speech, WIAT, ED Psych)**	
School Counsellor:	**Family Doctor:**
Mental Health Therapist:	**Others Involved:** Pediatrician, Psychologist, Psychiatrist, Child Services -
Has this child been referred to the Glenrose Mental Health clinic? Y or N	

Caregiver Information

Primary Name:	**Secondary Name:**
Relationship:	**Relationship:**
Phone:	**Phone:**
Email:	**Email:**

Current concern(s)

Current/previous diagnoses (please specify current vs. previous and from whom):_____

_____

Current and/or previous medications (please specify current vs. previous and from whom): _____

_____

Current/previous treatments or programs (school programs, FSCD, CASA, etc):_____

_____

FAX REFERRAL TO:
CAMHC Support Staff
Ph: 587-201-1924, Fax. 780-826-6362

BONNYVILLE child & adolescent MENTAL HEALTH COLLABORATIVE

Reason(s) for referral:_____

Goal of referral:_____

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