Appendix C: Community Mental Health Program Referral Form

Name of Youth: _____ **Age:** _____ **Date of Birth:** _____
Gender: _____ **HC #:**_____
Youth's Phone #:_____
Email: _____ **Facebook:** _____
Current Address:_____
Attending school? If so, name of school:_____
Community of Origin: **Cultural Background:**

High Risk Behaviors (i.e. dangerousness, runaway, sexual aggression)?	**Yes / No**
Does the youth have academic failure (been suspended/missed credits)?	**Yes / No**
FACS/CAS/CCAS involvement?	**Yes / No**
Youth Justice involved?	**Yes / No**
Does parent have mental illness?	**Yes / No**

Do you have concerns that the youth is going to hurt themselves/someone else in the next week?_____

Issue of Concern	**In the Last Month?**
Thoughts of suicide	yes / no
Previous suicide attempts	yes / no
Self harming behaviour	yes / no
Thoughts of harming behaviour	yes / no
Angry/aggressive outbursts	yes / no
Been inpatient for mental health	yes / no
Been to Barrett/EPAU/CHYME	yes / no
Substance use	yes / no

Current Medications:_____
Prescribed by: _____
Pharmacy:_____
How many pills are left:_____ Number of refills: _____
Has the youth seen a mental health clinician/psychiatrist/pediatrician/been hospitalized for mental health reasons? Yes / No
If so, complete PHIPA/fax and attach confirmed fax copy

Referral Source: **Date:** _____
Name of worker: _____
Case Manager:_____
Organization:_____ Phone Number: _____

Please rate on a scale from 1 (low) – 5 (high) the concerns for this youth: _____
Note:
_____
_____