Lakeridge Health

CHILD YOUTH AND FAMILY PROGRAM
EXTERNAL REFERRAL FORM

FAX COMPLETED FORM TO (905) 721−4881

1. CLIENT/PATIENT DEMOGRAPHIC INFORMATION

Legal name: (last name, first name):	Date of birth: ____ /____ /____ (dd / mm / yy)
Preferred name (if applicable):	Age:
Address:	Apartment/Unit #:
City:	Postal code:
Primary contact number:	Secondary contact number:
Health card number:	Version code: / Expiry:

What is your client/patient's gender? Check **ONE** only:		What is your client/patient's sex? Check **ONE** only:
☐ Female ☐ Male ☐ Trans (Female−to−Male) ☐ Trans (Male−to−Female)	☐ Two Spirit ☐ Intersex ☐ Do not know ☐ Prefer not to answer	☐ Female ☐ Male ☐ Intersex ☐ Prefer not to answer

2. GUARDIAN CONTACT INFORMATION

Guardian #1 name:	Relationship to client/patient:
Primary contact number: ☐ Home ☐ Work ☐ Cell	Secondary contact number: ☐ Home ☐ Work ☐ Cell
Guardian #2 name:	Relationship to client/patient:
Primary contact number: ☐ Home ☐ Work ☐ Cell	Secondary contact number: ☐ Home ☐ Work ☐ Cell

3. CONSENT

Does the client/patient consent to guardian consultation/involvement with this referral? ☐ Yes ☐ No ☐ Yes, but with limitations (please specify) _____

4. CUSTODY STATUS (IF APPLICABLE)

☐ Lives with both parents ☐ Sole custody ☐ Client/patient lives independently ☐ Joint custody (both parents **MUST** be made aware of this referral) ☐ Other (e.g., CAS/relative): _____

5. REFERRAL SOURCE INFORMATION

Name (last name, first name):		Billing number:
Address:	Unit #:	City:
Postal Code:	Phone:	Fax:

6. REFERRAL REQUEST

a) Medication Consultation? ☐ Yes ☐ No	b) Diagnostic clarification? ☐ Yes ☐ No

7. MEDICATIONS (psychiatric and non−psychiatric; attach additional information if needed)

Medication	Current	Past	Dose/Frequency	Response/Adverse Effects
	☐	☐		
	☐	☐		
	☐	☐		

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8. REASON(S) FOR REFERRAL		Primary (select **ONE**)	Secondary (if relevant)
Depression (sad, irritable, hopeless, poor sleep, crying, social withdrawal/isolating, lack of interest, decreased energy)		☐	☐
Hypo/Mania (elevated, expansive or irritable mood, coupled with abnormally and persistently increased goal−directed activity or energy; inflated self−esteem/grandiosity; decreased need for sleep; more talkative; flight of ideas; distractibility)		☐	☐
Anxiety (specify):	i) ☐ Obsessive thoughts, rituals or compulsions	☐	☐
	ii) ☐ Specific or social phobia, panic attacks, or generalized	☐	☐
Trauma/Post−Traumatic Stress (including flashbacks, intrusive memories, numbness or detachment)		☐	☐

9. ADDITIONAL AREAS OF CONCERN*

(*The following disorders/issues **ARE NOT** a primary reason for referral to our clinic, but might be comorbid and/or related concerns.)

- ☐ Alcohol or substance use/abuse
- ☐ Antisocial or oppositional behaviour (e.g. theft, assault, truancy, running away from home, fire setting, lying)
- ☐ Developmental issues (e.g. developmental delay, intellectual disability, autism)
- ☐ Dysfunctional eating (e.g. bingeing, purging, restricting, compulsive exercising, excessive dieting)
- ☐ Self−injurious behaviours (e.g. cutting, burning, scratching, punching)
- ☐ Attention Deficit Hyperactivity Disorder (ADHD) (e.g. inattention, hyperactivity, impulsivity)
- ☐ School issues (e.g. learning disability, school refusal, behavioural issues, bullying, peer conflict)
- ☐ Other (e.g. anger management). If other, please explain:

10. RISK ISSUES

	Check	If yes, how recent: 30 days, 6 months, 1 year	Details
Suicide attempt/ideation	☐ Yes ☐ No		
Deliberate self−harm	☐ Yes ☐ No		
Violent behaviour	☐ Yes ☐ No		
Legal involvement	☐ Yes ☐ No		
Fire setting	☐ Yes ☐ No		

11. OTHER SERVICE PROVIDERS (Please specify the status of the client/patient's involvement with each agency)

☐ **I have forwarded all prior assessment/treatment/discharge summary notes along with this referral to CYFP Intake**

Agency Name/Service Provider	Referred	Past	Current
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐

12. ADDITIONAL COMMENTS:

NOTE: If this referral form is submitted to CYFP Intake incomplete, it will be returned to you for your completion.

FOR OFFICE USE ONLY	New CYFP patient? ☐ Yes ☐ No Intake Worker Initials:_____	Unique #:	Pre−Registration Date: ____/____/____ (dd / mm / yy)