BRITISH COLUMBIA

Ministry of Children and Family Development

CHILD AND YOUTH MENTAL HEALTH INTAKE AND REFERRAL FORM

Fax: 604-983-0615
Phone: 604-904-4336

Date (yyyy/mm/dd)	Referral Source (Self, Physician, Teacher):	Referral Contact (Phone/Fax):

Client Information

Name of Client

Gender ☐ M ☐ F	Date of Birth (yyyy/mm/dd)	Personal Heath Number (PHN#)

Address

City/Town	Postal Code

Home Phone Number	Cell Phone Number

Name of Parent(s)/Legal Guardian(s)

Address

City/Town	Postal Code

Home Phone Number	Work Phone Number

Reason for Referral and Presenting Problems

Has Client/Family been consulted about this referral?
☐ Yes ☐ No
Comments:

Medical Information

Name of Primary Physician or Psychiatrist	Phone Number	Has Client given consent to contact Physician/Psychiatrist ☐ Yes ☐ No
Previous Mental Health Care & Date(s) (If Applicable)	Current Medications	
Other Professionals involved (If Applicable)	Past Diagnosis (If Available)	

Education Information

Name of School Attended by Client	Grade Attended by Client	Has Client given consent to contact school ☐ Yes ☐ No
School Contact name	Phone Number	

Comments and Additional Information:

Is this an Urgent Referral ☐ Yes ☐ No	Signature:	Date Signed (yyyy/mm/dd)