Mental Health Services For Children & Youth

CONFIDENTIAL

Physician Referral Form

Information on the Child/Youth

Child/Youth First Name: _____ **Last Name:** _____

Date of Birth: _____ /_____ / _____ **Gender:** ☐ Male ☐ Female ☐ Other _____
Day Month Year

Address: _____ _____
Street *Apt. #*

_____ ON _____ - _____
City/Town *Prov* *Postal Code*

Legal Guardian First Name: _____ **Legal Guardian Last Name:** _____

Legal Guardian Phone: (_____) _____ - _____ **Can Message be left?** ☐ Yes ☐ No

Who should be contacted for this referral?

First Name: _____ **Last Name:** _____

Phone: (_____) _____ - _____ **Can Message be left?** ☐ Yes ☐ No

Reason for Referral:

Physician Name:
Physician Address:
Physician Phone #:
Physician FAX #:

Billing Number: _____

Date of Referral: _____ / _____ / _____ _____
Day Month Year *Physician Signature*

FAX completed form to (905) 696-0352
Centralized Intake Phone#: (905) 451-4655

Intake completed: _____ /_____ / _____ ☐ **Unable to contact family** ☐ **Family declined Intake**
Day Month Year ***If family unable to be contacted or declined, please follow up with family.***