Child & Youth Mental Health Services

Cornwall Community Hospital/Hôpital communautaire de Cornwall
850 McConnell Avenue, Cornwall ON, K6H 4M3 – Phone: 613-361-6363 Ext. 8764 – Fax: 613-361-6364

Office Use Only:

Date Received:	☐ First Referral ☐ Re-referral

Client Information

Legal Names:	DOB (yyyy/mm/dd):	Age:
Preferred Name:	Pronouns: ☐ He/him ☐ She/her ☐ They/them Specify:_____	
OHIP # & Version Code: Expiry Date:	Sex: ☐ Male ☐ Female ☐ Intersex: _____	Gender: ☐ Male ☐ Female ☐ Non-binary
Primary Address:	City:	Postal Code:
Youth's Phone Number:	Contact Youth Directly for Booking: ☐ Y ☐ N	
School/Day Care:	Grade:	

Family Information

Who has the legal right to make decisions for this youth? (Custody)

☐ Parent/Guardian 1 ☐ Parent/Guardian 2 ☐ Both ☐ Youth ☐ CAS ☐ Other (specify):

The youth lives with?(Residency)

☐ Parent/Guardian 1 ☐ Parent/Guardian 2 ☐ Both ☐ Foster /Kinship ☐ Other (specify):

Parent/Guardian 1:		
Address:		Relationship:
Telephone Numbers	Primary:	Alternate:
Parent/Guardian 2:		
Address:		Relationship:
Telephone Numbers	Primary:	Alternate:
Non-Custodial Parent(s):		
Relationship & Access/Visitation:		

►***Siblings or other children living in the custodial home***

Name:	Age/DOB:
Name:	Age/DOB:
Name:	Age/DOB:
Name:	Age/DOB:

►***Medical Information***

Family Physician:	Physician Tel. Number:
Current Diagnosis: ☐ Yes ☐ No Describe:	Medication(s): ☐ Yes ☐ No Medication(s) & Dosage:

►***Please list current or previous contact with other hospital programs or community agencies***

Agency/Service	Period of Involvement	Worker	Closing Date
☐ CHEO Development & Rehab/OCTC	☐ Current ☐ Previous ☐ Waiting List		
☐ CHEO Mental Health/PSU	☐ Current ☐ Previous ☐ Waiting List		
☐ Children's Aid Society	☐ Current ☐ Previous ☐ Waiting List		
☐ Children's Treatment Centre	☐ Current ☐ Previous ☐ Waiting List		
☐ L'équipe psycho-sociale	☐ Current ☐ Previous ☐ Waiting List		
☐ S.D.&G. Developmental Services	☐ Current ☐ Previous ☐ Waiting List		
☐ Champlain LHIN – MHAN	☐ Current ☐ Previous ☐ Waiting List		
☐ Other:	☐ Current ☐ Previous ☐ Waiting List		

►***Please answer the following questions for referral***

► Is the child or youth referred for services at risk to harming themselves or others?

☐ No ☐ Yes (please explain): _____

_____

_____

► What concerns have brought you to our services?

☐ Symptoms of anxiety	☐ Parent or caregiver support	☐ Suspected/diagnosed eating disorder
☐ Symptoms of depression	☐ Child/Parent relationship difficulties	☐ Specific mental health diagnosis
☐ Self-harming behaviours	☐ Addictions or substance-use	☐ Difficulties regulating emotions
☐ Aggression and violence	☐ Self-esteem issues	☐ Trauma:_____
☐ Family conflict	☐ School related issues: _____	_____
☐ Suicidal ideation or attempts	_____	_____

☐ Other: _____

_____

_____

► Using the rating scale below, from the perspective of the child/youth, how are things in their lives today?

Worst ☹ 1 2 3 4 5 6 7 8 9 10 ☺ Best

►***By signing this form, I am acknowledging and consenting for this request for service to be made.***

Parent or Client Name (Please Print)	Parent or Client Signature	Date (yyyy/mm/dd)

Referral form must be signed by parent or client or referral will not be accepted