Last Name ____________________ First Name ____________________
PIN ____________________ Gender ____________________
Address ____
____
DOB ____________________ Home Phone ____________________
Work Phone ____________________ Cell ____________________

PCN Child & Youth Mental Health Clinic Referral Form

Phone:780.608.4927 Fax:780.608.4931

Date of Referral ______________________________ Family Physician ______________________________

Referred by ☐Physician ______________________________ Phone ____________________

☐Other ______________________________ Phone ____________________

NOTE: All guardians/parents and the patient must be aware of and agree to this referral.

Legal Guardian / Parent: ____________________ Legal Guardian / Parent (2): ____________________

Relationship: ____________________ Relationship: ____________________

Phone: ____________________ Phone: ____________________

Email: ____________________ Email: ____________________

Is there a custody agreement in place? ☐ **Yes** ☐ **No** If yes, primary guardian: ____________________

Patient/client consents to phone message being left to book appointment? ☐ **Yes** ☐ **No**

Additional Information: If referral is made by a school resource the following information must be included

School: ____________________ Grade: _______School Counsellor / Family School Liaison Worker: ____________________

Please provide any relevant documents (ISP, Psychosocial-Educational Assessments, other school based mental health assessments)

Reason for Referral:	**Current/previous diagnoses (please provide details if known including dates and diagnosing provider):**
☐ Assessment/Diagnosis	☐ ADHD ____________________
☐ Medication Review/Adjustment	☐ Anxiety ____________________
☐ Initiate Treatment	☐ Depression ____________________
☐ Resource Navigation	☐ Other ____________________
☐ Other ____________________	

Please list the patient's current and previous medications:

Medication Name	Dosage	Frequency	Presently Taking
			☐ **Yes** ☐ **No**
			☐ **Yes** ☐ **No**
			☐ **Yes** ☐ **No**☐
			☐ **Yes** ☐ **No**
			☐ **Yes** ☐ **No**

Current/previous services accessed or supports in place:
☐ **Family and Community Services**
☐ **Family Support for Children with Disabilities**
☐ **Alberta Health Services Mental Health & Addictions**
☐ **Child, Adolescent and Family Mental Health**
☐ **Other** ____________________
☐ **Other** ____________________

Revised December 2023

Reason for Referral:

What is the goal of this referral (ex: assessment, diagnosis, medication trial/review, counselling):

Additional Comments: