# Community Mental Health Services Child and Youth Referral

**FOR Mental Health Services OFFICE USE ONLY:**  
Month __________________ Referral#: ______ New_____ or Readmit______

## Parent Information
- **Mother's Name** (current and previous if known):
- **Father's Name**:
- **Marital Status**:
- **Custody Status**:

## Referral Source
- **Referral Source**:
- **Contact Name**:
- **Telephone Number**:

## Is this referral court ordered?
- **Yes**
- **No**

## Family Physician
- **Pediatrician**:
- **Psychiatrist**:

## Other professionals, care givers, or supports involved:

## Current Medications:

## What action is requested:
- **Assessment**
- **Consultation**
- **Medication Review/ Advice**
- **Therapy**
- **Other**

(circle most appropriate and explain)

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### Affective Symptoms
- Anxiety
- Phobias
- Depression / Bipolar

### Vegetative Symptoms
- Sleep disturbance
- Appetite or weight gain / loss / eating difficulties

### Psychotic Symptoms
- Delusions
- Hallucinations
- Paranoia
- Other

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<th>Check those that apply</th>
<th>Yes</th>
<th>No</th>
<th>Details</th>
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<td>Other</td>
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<td>Duration of current difficulties:</td>
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