Health PEI

COMMUNITY MENTAL HEALTH SERVICES
CHILD AND YOUTH REFERRAL

Richmond Centre, PO Box 2000
Charlottetown, PE C1A 7N8
Fax: 902-368-4427

FOR Mental Health Services OFFICE USE ONLY:
Month _____ Referral#:_____New_____ or Readmit_____

REFERRAL INFORMATION			
Name of Child or Youth being referred:	**Date of Birth:** **Yr_____ Mo_____ Day_____**	**Sex** **M__ F__**	**Personal Health Card Number:**
Mailing Address: (include mailing and civic)			
Telephone : **Home:** **Cell:** **Email (of youth if preferred method of contact):**			
Next of Kin / Guardian:			**Telephone Number:**
School normally attends, and grade:			

PARENT INFORMATION	
Mother's Name (current and previous if known):	**Father's Name:**
Marital Status:	**Custody Status:**

Referral Source:	**Contact Name:**	**Telephone Number:**
Is this referral court ordered?		
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)		

	Check those that apply	**Yes**	**No**	**Details**
Affective Symptoms	Anxiety			
	Phobias			
	Depression / Bipolar			
Vegetative Symptoms	Sleep disturbance			
	Appetite or weight gain / loss/ eating difficulties			
Psychotic Symptoms	Delusions			
	Hallucinations			
	Paranoia			
	Other			

	Check those that apply	Yes	No	Details
Cognitive Symptoms	Change, or difficulty in short term memory			
	Change ,or difficulty in long term memory			
	Change, or difficulty in concentration			
	Obsessions / Compulsions			
Physical Health	Change in energy level			
	Medical / health related problems			
Risk Assessment/ Suicide	Previous attempts			
	Current thoughts			
	Current plan			
	Engages in self harming behaviors			
	Risk of harm to others			
Substance Abuse	Alcohol Marijuana			
(Circle those relevant)	Other (street drugs, over the counter, etc)			
Life Stressors	Victim of abuse? Perpetrator of abuse?			
(Indicate physical,	Has abuse been reported?			
sexual or emotional)	Losses or separation			
	Legal issues (self or family, including family court)			
Functioning Problems	At work At home			
	In the community With family			
	At school Other			
	Loss of interest, or motivation			
Behavior / Social Problems	Conduct difficulties , opposition, truancy, risk taking, impulse control, school suspensions			
	Social withdrawal, isolation , conflict			
Developmental	Autistic symptoms, congenital disorder			
Learning Problems	Learning disabilities, intellectual difficulties			

Presenting Problem:

Duration of current difficulties: **Less than 1 month** ☐ **1-6 months** ☐ **6-12 months** ☐ **More than 1 year** ☐

DATE:_____ SIGNATURE:_____

DISPOSITION OF REFRERRAL: Date of case assignment:_____ To Whom:_____

On Hold:_____Explanation:_____

Wait List: _____Explanation:_____Date:_____

Referred: _____Where:_____Date:_____

Filed (date and reason):_____