

REFERRAL FORM *(Please print)*
Request for Services: Mental Health Services: Child and Youth (0-18 years old)

Mail or Fax to:
MENTAL HEALTH SERVICES
CENTRALIZED INTAKE
2nd Floor – 715 Queen Street
Saskatoon SK S7K 4X4
Phone: 655-7950 Fax: 655-7811

Date: _____

Referral Source Information:

Name: _____ Phone: _____

Organization: _____

Address: _____

Client Information: *(Please ensure client information is current and complete)*

Name: _____ DOB: _____ Age: _____ M/F _____

Address: _____ Health Card # _____

Phone #: _____ (Home) _____ (Caregiver's Work #)

Caregiver(s): _____ Relationship: _____

_____ Relationship: _____

Referral Information:

Please describe the presenting mental health problem to be assessed:

School Information:

School Name: _____

School Contact: _____ Grade: _____

List any other agency/professional involvement with this child/youth:

Name: _____ Phone: _____

Name: _____ Phone: _____

.: Please attach any relevant assessments or documentation that my support this referral.

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