MENTAL HEALTH AND ADDICTION SERVICES CENTRALIZED INTAKE
Child & Youth Program 715 Queen Street Saskatoon, SK S7K 4X4 Phone # 655-7777 Fax #655-7437

GENERAL REFERRAL FORM FOR CHILD AND YOUTH SERVICES

Date of referral: _____

Urgent Referral call 306-655-7777 Directly

☐ **Children's Services (0 - 11 years)**

☐ **Youth Community Counselling Services (12 - 18 years)**
☐ **Is this referral for Outreach**
- Is/are the parent(s) aware of this referral? Y / N
- Is the youth aware of this referral? Y / N
- Can we contact the parent(s)? Y / N

Client Information:

Name: _____

DOB: _____ Age: _____ ❑ Male ❑ Female

Address: _____ Postal Code: _____

Health Card # _____

Phone #: _____

❑ Status Aboriginal ❑ Non-Status Aboriginal ❑Metis ❑ Caucasian ❑ Immigrant/Refugee ❑ Other _____

Language: ❑ English ❑ Other ❑ Interpreter Required _____

Parent(s)/Guardian: Name & Relationship (parent/ step-parent; grandparent; foster parent):

_____

_____

Home Phone: _____ Cell: _____ Work: _____

Siblings: Name _____ Age ___ Name _____ Age ___

Name _____ Age ___ Name _____ Age ___

Referring Person & Position: _____ Phone: _____

School: _____

Address: _____

Teacher: _____ Current Grade: _____

Are school supports involved with this child/youth? (speech/language/OT/counselling) Y / N

If yes, please specify: _____

Has any psychological testing been done on this child/youth? Y / N ☐ Unknown

Is this student in a regular or modified program? ☐ Regular ☐ Modified

Does the child/youth have any learning difficulties? _____

Attaching a completed **CHILDERN'S SERVICES SCHOOL REPORT FORM** with the above reports would be helpful.

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Client Name: _____

If this child/youth is in the care of MSS or has a MSS worker, please provide the workers name and phone number:

Social Worker: _____ Phone: _____

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

Name: _____ Phone: _____ ☐ Past ☐ Present ☐ Ongoing

Name: _____ Phone: _____ ☐ Past ☐ Present ☐ Ongoing

Is the referring concern related to Suicide? Y / N

If ***YES*** complete this section:

Suicide Risk Assessment

Person who completed risk assessment: _____ Date: _____ Not Completed ___

Level of Risk: Low___ Medium ___ High ___

Parent/Guardians Notified? Y / N

Safety Plan (please attach copy):

_____

_____

Primary Reason for Referral – CHECK ONE

- ❑ Behavioral Concerns
- ❑ Trauma
- ❑ Anxiety
- ❑ Depression
- ❑ Substance use/misuse
- ❑ Family stressors
- ❑ Non-Suicidal Self Harm

Additional Concern(s)

- ❑ Behavioral Concerns
- ❑ Trauma
- ❑ Anxiety
- ❑ Depression
- ❑ Substance use/misuse
- ❑ Family stressors
- ❑ Non-Suicidal Self Harm

Please describe symptoms of primary concern:

_____

_____

_____

_____

Please describe symptoms of additional concern:

_____

_____

_____

_____

An assessor/coordinator will contact the parent, guardian or youth regarding the referral. For questions, please call Centralized Intake at (306) 655-7777.

<u>For emergency services</u>, please contact Mobile Crisis at 306-933-6200, the Saskatchewan Health Line at 811, call your child's physician or visit the hospital emergency room.

If this is a youth referral, please have **youth** (14 and up) sign this form.

Parent, Guardian or Client Signature _____ Date _____