Addressograph / Label

NAME: _____

HSN: _____

D.O.B.: _____

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

MSS REFERRAL FORM FOR CHILD AND YOUTH SERVICES

Date of referral: _____

☐ **Children's Services (0 - 12 years)**
☐ **Youth Community Counselling Services (13 - 18 years)**

MSS/Community Corrections Worker making referral**:** _____

Phone**:** _____

Address: _____

Role: _____

Other MSS/CC Worker involved:_____ Phone: _____

Client Information:

Name: _____

DOB: _____ Age: _____ ❑ Male ❑ Female

Address: _____ Postal Code: _____

Health Card # _____

Phone #: _____

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

Language: ❑ English ❑ Other ❑ Interpreter Required _____

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

_____

_____

Home Phone: _____ Cell: _____ Work: _____

List all other agency/professional involvement with this youth:

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

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

School: _____ **Grade:** _____

Family of Origin Information:

	Name	Age	Address	Phone	Father Name
Mother:	_____	_____	_____	_____	
Father:	_____	_____	_____	_____	
Sibling:	_____	_____	_____	_____	_____
Sibling:	_____	_____	_____	_____	_____
Sibling:	_____	_____	_____	_____	_____
Sibling:	_____	_____	_____	_____	_____
Sibling:	_____	_____	_____	_____	_____
Sibling:	_____	_____	_____	_____	_____

MSS Is there an active investigation? Y / N

Will MSS Remains Involved after referral?: Y / N

Parental Services Agreement: Y / N Expiry Date: _____

Temporary Ward/Section 9: Y / N Expiry Date: _____

Long Term or Permanent Ward: Y / N

Custody, Supervision and Rehabilitation Services (Ministry of Justice)

Remand: Y / N

Custody: ❑ Open ❑ Closed Expiry Date:_____

Community Sentence: Y / N Expiry Date:_____

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

If ***NO***, please provide reason the parent/guardian has not been informed:

_____

_____

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

Please describe symptoms of primary concern:

_____

_____

_____

_____

Additional Concern(s) – Please select all and provide details

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

Please describe symptoms of additional concern(s):

_____

_____

_____

_____

For questions regarding referrals, 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 the child's physician or visit the hospital emergency room.

Parent, Guardian, Client Signature _____ Date _____