REFERRAL FORM

London Health Sciences Centre

Child and Adolescent Mental Health Care Program
Intake Office
Ph #: (519) 667-6640

Please Fax Referral to: (519) 667-6814
Total # of pages (including this page): _____

Age criteria**: *Outpatients*** ages 15 and under, ***Inpatients*** 8-15 yrs., ***Day Treatment*** 10-17 yrs,
Eating Disorders - consultation and treatment for ages 17 yrs and under, consultation for ages 18-25 yrs

*For referrals regarding **EATING DISORDERS**: please contact our office and we will fax an eating disorders referral form.

Name of child/adolescent: _____ Sex: M F

Date of Birth: _____ Age: _____ Health Card Number _____

Please provide name of parent/guardian: _____

Phone number(s)-Home: _____ Work: _____

Mailing Address: _____

_____

Has the parent/guardian been informed of the referral? Yes No

If not, please do so before submitting this referral.

Referral Agent: _____ Role with child/family: _____

Phone Number: _____ FAX Number: _____

Mailing Address: _____

_____

Detailed reason for referral: _____

_____

_____

_____

_____

Clinical Urgency (please circle one): Crisis Urgent Semi-urgent Elective

Intensity of service sought (circle only one): Inpatient Outpatient

Date/Completed by:_____