Bonnyville Child & Adolescent
MENTAL HEALTH
COLLABORATIVE

# Child & Adolescent Mental Health Clinic Referral Form

**Person Sending Referral**

| | |
|---|---|
| Name: | Date of Request |
| Position | Phone Number |

******** EACH QUESTION ON THE FORM MUST BE COMPLETED********

Have you explained the multidisciplinary team members to the parents? Y or N

Have you suggested to the parents to have the child seen by their family doctor/NP? Y or N

Does the family need: Community resource navigation and/or Assessment from clinical team

Have the caregiver(s)/parent(s) completed a parenting program? Y or N _____

Is the child displaying symptoms of ADHD, anxiety or depression? Y or N

If so, which one?_____

**Client Information**

| | |
|---|---|
| **Name:** | **DOB (yy/mm/dd):** |
| **Age:** | **Gender/Pronouns:** |
| **School:** | **Grade:** |
| **Assessments Completed:**<br>**(OT, Speech, WIAT, ED Psych)** | |
| **School Counsellor:** | **Family Doctor:** |
| **Mental Health Therapist:** | **Others Involved:** Pediatrician, Psychologist, Psychiatrist, Child Services - |
| **Has this child been referred to the Glenrose Mental Health clinic? Y or N** | |

**Caregiver Information**

| | |
|---|---|
| **Primary Name:** | **Secondary Name:** |
| **Relationship:** | **Relationship:** |
| **Phone:** | **Phone:** |
| **Email:** | **Email:** |

**Current concern(s)**

Current/previous diagnoses (please specify current vs. previous and from whom):_____

_____

Current and/or previous medications (please specify current vs. previous and from whom): _____

_____

Current/previous treatments or programs (school programs, FSCD, CASA, etc):_____

FAX REFERRAL TO:
Mental Health Navigator
Ph: 780-826-3346, ext 234, Fax. 780-826-6362

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Reason(s) for referral:_____
_____
_____
_____
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Goal of referral:_____
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_____

For Clinic Use

Clinic Intake Number:_____

Calls to Primary Parent/Guardian:_____
_____

Accepted Into Clinic: Yes / No

Date of Scheduled Intake: _____

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