Community Addiction and Mental Health Services
Services communautaires de santé mentale et de dépendances

Referral Form

Child & Youth Mental Health Services

Cornwall Community Hospital/Hôpital communautaire de Cornwall

850 McConnell Avenue, Cornwall ON, K6H 4M3 – Phone: 613-361-6363 Ext. 8764 – Fax: 613-361-6364

Date of Referral:	Referral Source:

Office Use Only:	
Cerner #:	
Screened by:	Date Screened:
☐ First Referral	☐ Re-referral

Client Information		
Legal Name:	D.O.B.:	Age:
Preferred Name:		
OHIP # & Version Code: Expiry Date:	Sex: ☐ Male ☐ Female ☐ Intersex: ________	Gender: ☐ Male ☐ Female ☐ Non-binary
Primary Address:	City:	Postal Code:
Youth Phone Number:	Contact Youth Directly: ☐ Y ☐ N	
School/Day Care:	Grade/Placement:	

Family Information
Who has the legal right to make decisions for this youth?
☐ Parent/Guardian 1 ☐ Parent/Guardian 2 ☐ Both ☐ Youth ☐ CAS ☐ Other (specify):
Youth resides with:
☐ Parent/Guardian 2 ☐ Parent/Guardian 2 ☐ Both ☐ CAS ☐ Other (specify):

Parent/Guardian 1:		
Address:		Relationship:
Telephone Numbers	Primary:	Work:
	Alternate:	

Parent/Guardian 2:		
Address:		Relationship:
Telephone Numbers	Primary:	Work:
	Alternate:	

Non-Custodial Parent(s):	
Relationship & Access:	

Referral Form

►*Siblings*

Name:	Age/DOB:
Name:	Age/DOB:
Name:	Age/DOB:
Name:	Age/DOB:

►*Medical Information*

Family Physician:	Physician Tel. Number:
Medical/Psychiatric Diagnosis: ☐ Yes ☐ No Describe:	Medication(s): ☐ Yes ☐ No Describe:

►*Current/previous contact with other hospital/community program(s)?*

Agency/Service	Period of Involvement	Worker	Closing Date
☐ CHEO	☐ Current ☐ Previous ☐ Waiting List		
☐ Children's Aid Society	☐ Current ☐ Previous ☐ Waiting List		
☐ Children's Treatment Centre	☐ Current ☐ Previous ☐ Waiting List		
☐ Eastern Ontario Health Unit	☐ Current ☐ Previous ☐ Waiting List		
☐ Counselling & Support Services of SD&G	☐ Current ☐ Previous ☐ Waiting List		
☐ L'Équipe Psycho-sociale	☐ Current ☐ Previous ☐ Waiting List		
☐ Mental Health Crisis Team	☐ Current ☐ Previous ☐ Waiting List		
☐ S.D. & G. Developmental Services	☐ Current ☐ Previous ☐ Waiting List		
☐ CCAC – MHAN	☐ Current ☐ Previous ☐ Waiting List		
☐ Other:	☐ Current ☐ Previous ☐ Waiting List		

►*Reason for Referral / Primary concern*

____

____

____

____

____

____

____

____

►Are the parent(s)/guardian(s) aware of this referral? ☐ Yes ☐ No

►Is the youth aware of the referral? ☐ Yes ☐ No

Please attach signed consent to the referral form