CHATHAM KENT CHILDREN'S SERVICES
495 Grand Avenue West
Chatham, Ontario N7L 1C5
Phone: (519) 352-0440 X 2
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MENTAL HEALTH /DEVELOPMENT REFERRAL FORM

Child/Youth's Name:	**Date of Birth**:	**Gender:**

Address: _____ _____ _____

Street **City** **Postal Code**

Phone: _____

Primary Contact (for scheduling service)

Name: **Relationship to child/youth:**

Phone: **Alternate Phone:**

Email Address:

Reason for Referral (current needs, symptoms, behaviors):

Current Risk Factors

Risk of Harm to Self? ☐ **Yes** ☐ **No**

Risk of Harm to Others? ☐ **Yes** ☐ **No**

Has the youth met with a mental health professional? ☐ **Yes** ☐ **No**

Has a safety plan been completed? ☐ **Yes** ☐ **No**

Please provide details of this plan (please attach any relevant documentation)

Referral Source

Name:

Phone number:

Consent to share information? ☐ **Yes** ☐ **No (if yes please attach)**

Parent and Child/Youth in agreement with referral? ☐ **Yes** ☐ **No**