

# Crisci & Mayer

CONSULTATION, COUNSELLING AND TRAINING

## CHILD AND YOUTH REFERRAL FOR SERVICES

(please complete separate form for each child/youth being referred)

FAX: (416) 480-2922  
Telephone: (416) 480-1611

*Note:*

- We offer assessment, treatment, and consultation. Please note that we **do not** offer emergency or immediate crisis services.
- For individuals/families who have had mental health services within the past year, please forward a copy of assessment and treatment reports, as well as referral concerns.
- Please **DO NOT** use this form when requesting services for adults. For adult client service requests, please call (416) 480-1611 ext. 224.

### REFERRED BY:

Contact Person(s) : \_\_\_\_\_

Agency Name: \_\_\_\_\_

Agency Address: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Telephone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_

Email Address: \_\_\_\_\_

**I am referring this client for (please check appropriate boxes):**

- Assessment       Treatment       Assessment and Treatment
- Trauma       Sexualized Behavior       Other: \_\_\_\_\_  
(please be specific)

### REFERRAL INFORMATION:

Child/Youth:       Male      \_\_\_\_\_  
                          Female      First Name

Date of Birth: ( dd / mm / year ) Last Grade completed in school: \_\_\_\_\_

Child/Youth is a Crown Ward:       Yes       No

Child/Youth lives with:       both parents       mother only       father only       other: \_\_\_\_\_

Parents' Marital Status:       Married       Common-law       Separated       Divorced

Custody Status (if applicable):       Joint\*       Mother       Father  
    Other (i.e. CAS, relative): \_\_\_\_\_

If one parent has full custody, does the other parent have access?  Yes       No       don't know

**Reason for Referral:**

PLEASE DETAIL PRESENTING PROBLEM AND GOAL:

List all previous and current Mental Health Counselling Contacts/Assessments (*please attach copies of reports if available*):

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_
- 5. \_\_\_\_\_

Children's Aid Society Involvement?       Yes       No  
If yes, specify agency: \_\_\_\_\_

Psychological Testing?       Yes       No  
If yes, specify when and by whom: \_\_\_\_\_

Criminal Court Involvement?       Yes       No  
If yes, specify: \_\_\_\_\_

Family Court Involvement?       Yes       No  
If yes, specify where: \_\_\_\_\_

**Medical History:**

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_  
Current Medications: \_\_\_\_\_  
Medical Problems/Concerns: \_\_\_\_\_

**OFFICE USE ONLY:**

**Client #:** \_\_\_\_\_

Consultant: \_\_\_\_\_ Service Requested: \_\_\_\_\_  
Date Opened: dd/mm/year      Date Closed: dd/mm/year  
Billing Address: \_\_\_\_\_