

Physician Referral Form

Contact Niagara – The access point for child and youth counselling/psychiatry referral services within the Niagara Region. Our intake process will ensure your referral will be directed to the appropriate services FAX: 905-684-2728

Patient/Client's Personal	Informatior	If client is 16	+, are parents aware of	referral?	Yes	No
Name (incl. Preferred):		Health Card Number :				
Address :		City :	1	Postal Code	:	
DOB :	Age :	Gender :		Client Phor	ne:	
Parent/Contact Name :	Contact Phone :					
Parent/Contact Name :	Contact Phone :					
Resides with : (Choose)			Custody Type: N/A	Joint	Sole	Unknown
Family Physician :			Telephone :			
Psychiatrist :			Telephone :			

Referral Information

Referred by :		Date :	Physician's Billing # :	
Risks	Within 6 Over 6 months ago None Unknown		Within 6 Over 6 months months ago None Unknown	
Thoughts of suicide:		Thoughts of harm to	others:	
Suicide attempts:		Engaged in harm to c	others:	
Thoughts of self-harm	:	Substance/alcohol m	isuse:	
Engaged in self-harm:		High risk actions:		
		Police/legal involvem	nent:	

Reason for Request (Required):

Service(s) Requested:	Counselling/Therapy
	Psychiatric Consult (for Diagnostic Clarification and/or Medication follow-up)

Medication List of Current Medications-Please print clearly

Name of Medication	Dosage	Frequency
Allergies		

Consent and Agreement

I/, WE (Client/Patient/Guardian) AGREE TO THE EXCHANGE OF INFORMATION BETWEEN	I		
AND CONTACT NIAGARA. I ALSO AGREE TO A RESOURCE COORDINATOR CALLING			
ME FOR THE PURPOSE OF COMPLETING AN INTAKE.			
SIGNATURE	DATE		